COMMUNITY ALTERNATIVES PROGRAM FOR PERSONS WITH MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES

CAP-MR/DD MANUAL

June 22, 2005

North Carolina Department of Health and Human Services
Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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SECTION 1. OVERVIEW AND ADMINISTRATION

1.1 Overview

The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) is committed to making services and supports for adults and children with developmental disabilities available in the communities of their choice. This commitment is consistent with North Carolina's continuing efforts to reform the public mental health, developmental disabilities and substance abuse services system.

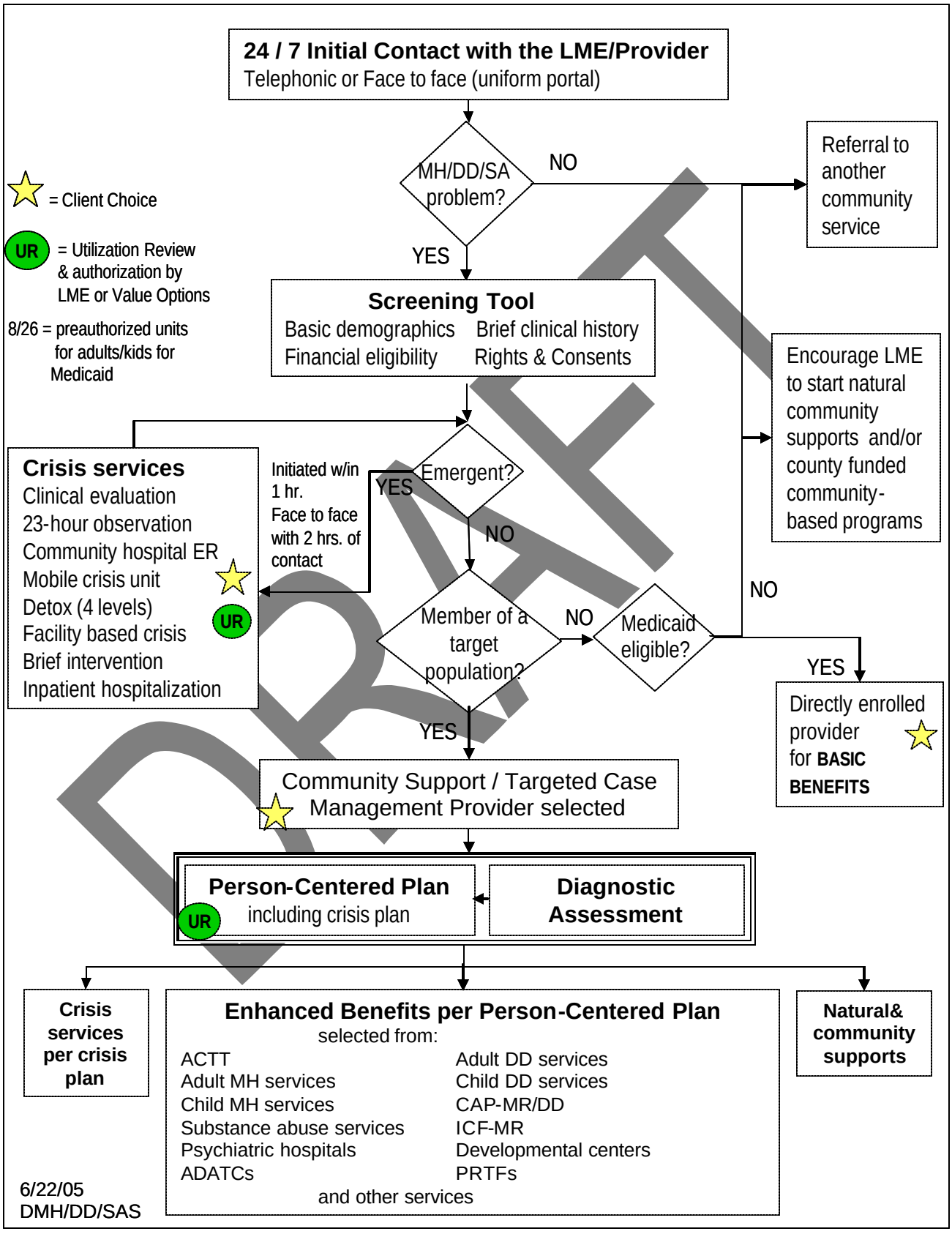
In the reformed system, all individuals have access to local mental health, developmental disabilities and substance abuse services and supports through a uniform process regardless of where the individual first contacts the system. An individual entering the system for the first time will experience a brief screening to determine basic needs, the urgency of the situation, clinical history and financial eligibility. If the individual's situation is emergent or urgent, appropriate crisis services are provided quickly. Otherwise, the screener makes an initial determination if the individual is a member of a target population. If so, they offer to the individual a choice of providers who will work with the individual and family/guardian to complete a person-centered plan – a fundamental part of the system reform – and begin the delivery of services. This general process is illustrated in the following flow chart. Access, screening and triage are discussed in detail in section 2 and person-centered planning is covered in section 4 of this document.

The goals of the Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP-MR/DD) are consistent with reform of the system. They are to:

- Address the needs of individuals in their community.
- Insure person-centered planning for each individual.
- Provide for simplicity and ease of service delivery.
- Lift the individual fiscal limit on available services and supports.
- Promote movement of individuals to the community from intermediate care facility for persons with mental retardation (ICF-MR) group homes and state developmental centers.

CAP-MR/DD is a Medicaid community care funding source for persons with mental retardation/developmental disabilities. It offers specific services in the community for individuals of all ages who require an ICF-MR level of care and gives a cost-effective alternative to care in an ICF-MR. ICF-MR level of care is described in detail in section 2.

Funding is authorized by a Medicaid Home and Community Based (HCBS) Waiver granted by the federal Centers for Medicare and Medicaid Services (CMS) under Section 1915 (c) of the


24 / 7 Initial Contact with the LME/Provider
Telephonic or Face to face (uniform portal)
MH/DD/SA problem?
NO
Referral to another community service
YES
= Client Choice
UR = Utilization Review & authorization by LME or Value Options
8/26 = preauthorized units for adults/kids for Medicaid
Screening Tool
Basic demographics
Brief clinical history
Financial eligibility
Rights & Consents
Encourage LME to start natural community supports and/or county funded community-based programs
Crisis services
Clinical evaluation
23-hour observation
Community hospital ER
Mobile crisis unit
Detox (4 levels)
Facility based crisis
Brief intervention
Inpatient hospitalization
Initiated w/in 1 hr. Face to face with 2 hrs. of contact
Emergent?
YES
NO
Member of a target population?
NO
Medicaid eligible?
NO
YES
Directly enrolled provider for BASIC BENEFITS
YES
Community Support / Targeted Case Management Provider selected
Person-Centered Plan
including crisis plan
Diagnostic Assessment
Crisis services per crisis plan
Enhanced Benefits per Person-Centered Plan
selected from:
ACTT
Adult MH services
Child MH services
Substance abuse services
Psychiatric hospitals
ADATCs
Adult DD services
Child DD services
CAP-MR/DD
ICF-MR
Developmental centers
PRTFs
and other services
Natural& community supports
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Social Security Act.[1] Both federal and state dollars fund Medicaid waivers. It should be noted and emphasized that the waiver is one funding mechanism supporting individuals with developmental disabilities in North Carolina. Other funding mechanisms are available through the Medicaid State Plan under Title XIX, state funded services and generic community resources. The current waiver was implemented September 1, 2005 and is effective for three years.

1.2 Target Population

If funding is available, a person with mental retardation/developmental disabilities may be considered for CAP-MR/DD funding if all of the following criteria are met:

1) The individual is eligible for Medicaid coverage.
2) The individual meets the requirements for ICF-MR level of care.
3) The individual resides in an ICF-MR facility or is at high risk of being placed in an ICF-MR facility.
4) The individual's health, safety and well being can be maintained in the community under the program.
5) The individual requires CAP-MR/DD services as identified through a family or person-centered planning process. An individual must require at least one waiver service as identified in the person-centered planning process and indicated in the Plan of Care and Cost Summary.[2] The person-centered planning process assists the individual with their family or guardian in identifying and accessing a personalized mix of paid and non-paid services that will assist him/her to achieve personally defined outcomes in the most inclusive community setting.
6) The individual, his/her family, and/or guardian desire CAP-MR/DD participation rather than institutional services.

1.3 Waived Medicaid Requirements

CMS may waive the following requirements in granting the waiver. These are the only requirements that may be waived under federal law[3]:

1) Statewideness: The Social Security Act requires Medicaid services to be provided on a statewide basis. In North Carolina CAP-MR/DD funding is available to residents in all counties, except those individuals whose Medicaid eligibility has been established in Cabarrus, Davidson, Rowan, Stanly and Union counties. The Piedmont Innovations

[1] This provision was added to the SS Act by 2176 of P.L.97-35 (Omnibus Reconciliation Act of 1981 and subsequently amended by P.L. 99-272 (Consolidated Omnibus Reconciliation Act of 1985), P.L. 99-509 (OBRA 1986), P.L.100-203. P.L. 100-360, P.L.100-647, P.L.508, and 4743 of P.L. 105-33.

[2] The Plan of Care is the waiver's name of the person-centered plan. See appendix A for a sample form.

[3] 1915 (c) of the Social Security Act

1915C Home and Community Based Waiver will serve individuals who are legal residents of those counties.

2) Comparable Services: The Social Security Act requires a state to provide comparable services in amount, duration and scope to all Medicaid recipients. This requirement is waived to allow CAP-MR/DD services to be offered only to CAP-MR/DD recipients.
3) Deeming of Income and Resources: Medicaid rules require that the income and resources of a spouse/parent be considered in determining Medicaid eligibility for a person who resides with a spouse/parent. This "deeming" of income and resources is to the Medicaid recipient. The deeming requirement is waived to allow Medicaid eligibility to be considered similar to the methods used for people who are residing in an ICF-MR facility.

1.4 Assurances

A state must provide various assurances to CMS to obtain a waiver. North Carolina has provided assurances regarding the following:

1) Health and Welfare of Recipients: Necessary safeguards are taken to protect the health and welfare of recipients.
2) Financial Accountability: There is financial accountability for funds expended for CAP-MR/DD services. The state will maintain and make available to the North Carolina Department of Health and Human Services (DHHS), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits. Records are kept for at least five years.
3) Need for ICF-MR Care: There is an initial evaluation and annual reevaluations of the need for ICF-MR Level of Care (LOC).[4] Written documentation of evaluations and reevaluations are maintained.
4) Recipient Choice: When a recipient is determined likely to require the level of care provided in an ICF-MR facility, the recipient or the recipient's legal representative will be informed of any feasible alternatives available under CAP-MR/DD and given the choice of either institutional or CAP-MR/DD services.
5) Cost-Effectiveness: The average per capita fiscal year expenditures under the wavier will not exceed the average per capita expenditures that would have been made in the fiscal year for ICF-MR LOC had the wavier not been granted. Also, the total expenditures for home and community-based services and other Medicaid services provided to individuals under the Waiver will not, in any year of the Wavier period, exceed the amount that would be incurred by Medicaid for these individuals in an ICF-MR facility in the absence of the Wavier.
6) Reports to CMS for Monitoring: The North Carolina Division of Medical Assistance will provide annual reports to CMS about the impact of the waiver on the type, amount and cost of services provided under the Medicaid State Plan and on the health and welfare of recipients. The information will be consistent with a data collection plan designed by CMS.

[4] ICF-MR level of care (LOC) is explained in section 2.

1.5 Waiver Administration

The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the lead agency for statewide operations of this waiver. The North Carolina Division of Medical Assistance (DMA) oversees the overall operation of the waiver according to federal and state guidelines. These divisions cooperate in the operation of the waiver under a memorandum of understanding that delineates each division's responsibilities.

The North Carolina General Assembly, in session Law 2001-437, designated the local mental health authorities as the "locus of coordination" for the provision of all publicly funded MH/DD/SA services. The local mental health, developmental disabilities and substance abuse authorities are known as local management entities (LMEs). Local management entities are the local lead agencies for the day to day operations of the waiver in the counties they serve. LMEs assure that the policies and procedures for all the programs in the public mental health, developmental disabilities and substance abuse services system are followed, including waiver services. LMEs are responsible for the health, safety and welfare of individuals receiving services, for assuring integrity of the provision of services and supports with the service plan/Plan of Care, and for assuring that individuals receive the appropriate level of care.

DMH/DD/SAS and DMA form a DHHS monitoring team that conducts statewide monitoring with periodic on-site reviews of each LME and provider agency. This is to assure and document that the provision of CAP-MR/DD services complies with the intent of the funding sources; DMH/DD/SAS standards and record processes; applicable federal and state laws, regulations, standards and guidelines; and CAP-MR/DD policies, procedures and instructions. DMA gives guidance to DMH/DD/SAS staff on Medicaid issues involved in these reviews. DMH/DD/SAS shares the final reports on the reviews of LMEs and provider agencies with DMA.

As noted above, LMEs are the local lead agencies for the day to day operations of the waiver in the counties they serve. Lead agency status may be reassigned per North Carolina Administrative Code General Statute 122-C 125.1: Area Authority failure to provide services; state assumption of service delivery.

1.6 Allocation of Funding

LMEs are provided an allocated share of the total state budget for CAP-MR/DD funding each year along with the projected number of consumers expected to be served with that funding amount. Reimbursement for waiver services is paid directly to service providers by the Medicaid agency upon the submission of clean/accurate billing claims. DMA is responsible for reimbursement policies and procedures. This includes provider agency enrollment, rate setting and claims processing.

The allocation is based on the historical and projected cost of waiver participants within the LME. LMEs are required to establish internal reporting mechanisms to track use of waiver funds. DMH/DD/SAS monitors the status of the LMEs' allocation by using information from

the Medicaid Paid Claims Information System. State information is shared with LMEs on a monthly basis.

DMH/DD/SAS and DMA jointly ensure that the actual total expenditure for home and community-based and other Medicaid services under the waiver and the claim for federal financial participation in expenditures for the services provided to individuals under the waiver do not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the state's Medicaid program for these individuals in the ICF-MR institutional settings.

SECTION 2. ASSESSMENT AND ACCESS TO SERVICES AND SUPPORTS

2.1 Access, Screening and Triage

People with mental retardation and developmental disabilities are referred for services and supports through an LME's access, screening and triage process. This process provides for uniform portal whereby the same elements exist for access regardless of whether the person enters the system through the LME or a provider. A brief screening and triage is conducted to determine if an issue related to mental retardation or developmental disabilities exists, to assess the urgency of the situation and to make an initial determination as to type of problem and target population.

If an individual is presumed to meet the target population criteria as having mental retardation or a developmental disability, the individual is referred for targeted case management services as well as diagnostic assessment, both of which are approved Medicaid service definitions and are preauthorized for 30 days. Should an individual/family contact a provider first, the provider is responsible for notifying the LME and ensuring that service authorization is received for the individual for targeted case management and diagnostic assessment. The diagnostic assessment serves as the basis for the person-centered plan. Both the diagnostic assessment and the person-centered plan must be completed within 30 days of referral.

2.2 Determination of ICF-MR Level of Care

An individual being considered for CAP-MR/DD funding must require the level of care provided by an ICF-MR facility. It should be noted that not everyone meeting DD target population will meet the ICF-MR level of care. During the diagnostic assessment process, **initial** determination may be made as to whether the individual meets the ICF-MR level of care. This assessment information is provided to the Targeted Case Management services for the person-centered planning process.

ICF-MR Level of Care determination is assessed and documented on the MR2 form by a physician or clinical psychologist licensed by the State of North Carolina.[5] The physician/licensed psychologist providing the assessment will complete the MR2 for individuals that based on the assessment results will meet the ICF-MR level of care (LOC).

ICF-MR criteria: To be Medicaid certified at the ICF-MR LOC, the individual must:

> Require active treatment necessitating the ICF-MR level of care. (Active treatment refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program).

[5] A sample MR2 form is shown in appendix A.

AND

Have a diagnosis of mental retardation **OR** a condition closely related to mental retardation as defined here.

A. Mental retardation is a disability characterized by significant limitations both in the intellectual functioning and in adaptive behavior as expressed in conceptual, social and practical adaptive skills. The disability originates before age 18.

B. Persons with closely related conditions refer to individuals who have a severe, chronic disability that meets **ALL** of the following conditions:

1. It is attributable to:
   a. Cerebral palsy or epilepsy; or
   b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons, and requires treatment or services similar to those required for these persons; **and**

2. It is manifested before the person reaches age 22; **and**

3. It is likely to continue indefinitely; **and**

4. It results in substantial functional limitations in three or more of the following areas of major life activity:
   a. Self-care.
   b. Understanding and use of language.
   c. Learning.
   d. Mobility.
   e. Self-direction.
   f. Capacity for independent living.

During the diagnostic assessment, **initial** determination of ICF-MR level of care **may** be made. If funding is available and the LME has authorized, the MR2 may be completed at the diagnostic assessment. If funds are not available, the MR2 is not completed at this time, but must be completed by a physician or licensed psychologist once funding has been identified as available by the LME. **The case manager is responsible for coordination of completion of MR2 in collaboration with staff of the LME when not completed at the diagnostic assessment.**

Individuals who are requesting CAP-MR/DD services and are assessed to have emergent or urgent needs during diagnostic assessment will be considered high priority for CAP-MR/DD funding if they meet the ICF-MR criteria. Individuals assessed with routine needs may be served on a first come, first serve basis for CAP-MR/DD funding. Funding, however, is based on availability, and therefore may not be guaranteed. In addition, the LME may have other individuals in the community or in an ICF-MR private or state facility that have previously

requested CAP-MR/DD funding and these individuals must also be considered for funding as new individuals enter the system.

A psychological evaluation must be available for all individuals within the developmental disability target population and must include an adaptive behavior assessment. For children the psychological assessment must have been completed within the last year; for adults the psychological assessment must have been completed within the last three years, unless there have been substantial changes in their situation, which may require a more recent update. If an individual is in need of additional assessments such as speech, physical therapy or occupational therapy evaluations, the case manager will be responsible for coordinating those assessments.

2.3 Final Determination of Level of Care (LOC)

Whether the MR2 is completed by the physician or licensed clinical psychologist during the diagnostic assessment or in coordination with the case manager, the MR2 must be signed by the appropriate LME staff and submitted to Murdoch Center. Clinical staff employed by DMH/DD/SAS through Murdoch Center will receive completed MR2 forms, as well as psychological evaluations, for all new waiver applicants in the state and will make the **final** determination of level of care.

The following provides critical timelines for completion and submission of the MR2 to Murdoch Center clinical staff by the LME, in collaboration with the case manager. As previously noted initial MR2s must be completed and signed by a physician or licensed psychologist. In addition, they must also be signed by staff of the LME.

- The LME must request Murdoch Center approval of the MR2 within 30 days of the date that the physician or licensed psychologist signs the form. A psychological evaluation including adaptive functioning must accompany the MR2 form.

- The LME faxes the completed form and psychological evaluation to Murdoch Center clinical staff for review. The LME must make sure that the name, address, and telephone number of the case manager responsible for the individual is enclosed with the MR2, in addition to their contact information. The MR2 and accompanying documentation should be faxed to the Senior Psychologist at 919-575-1083.

- Murdoch Center clinical staff reviews the MR2 and accompanying documentation and makes a decision within five business days.

- Once clinical staff of Murdoch determines that the individual meets the ICF-MR level of care the LME is notified via phone or fax of the prior approval number for entry into the MR2 line 13.

- LME staff must mail the original MR2 with prior approval number entered to Murdoch Center within 10 working days of fax or phone approval date. If the completed form does not reach Murdoch within this time, the prior approval number will be voided.

- Murdoch Center stamps each copy of the MR2 and maintains the white copy.

- Murdoch Center mails the original remaining copies back to the LME.

- The LME must mail the blue, stamped copy of the MR2 to the appropriate DSS, and the pink, stamped copy of the MR2 to the case manager within five days of receipt to insure that services begin in a timely manner and for entrance into the permanent record of the individual. The LME must retain a copy for their files.

The effective date of MR2 approval is the date that Murdoch Center gives telephone approval or the date that Murdoch Center enters in item 13 on the MR2. The effective date for CAP-MR/DD participation is the latest of three dates:

- Date of the Medicaid application;
- Date of the MR2 approval; or
- Date of deinstitutionalization.

Individuals who have been identified by the LME and referred for waiver funding who are being transitioned from institutions must have a new MR2 completed by a physician or licensed psychologist. In addition, the MR2 must be signed by staff of the LME. Staff of the LME will obtain the current prior approval number from the ICF-MR facility and enter it into line 13 of the MR2. As above, clinical staff of Murdoch Center will receive completed MR2 forms as well as psychological evaluations for all individuals transitioning from a state or community ICF-MR facility to the community and will make final re-determination of level of care. Critical timelines for completion and submission of the MR2 to Murdoch Center clinical staff are as follows:

- Staff of the LME must request approval of the MR2 within 30 days of the date the physician or licensed psychologist and the LME staff sign the form.
- The LME staff mails the completed MR2 and psychological evaluation to Murdoch Center. A letter must accompany the MR2 and psychological stating that the individual already has a prior approval number. Contact information for the LME staff as well as the case manager must also accompany the MR2.
- Murdoch Center staff reviews and makes a decision on ICF-MR level of care within five business days.
- Once clinical staff of Murdoch determines the individual to continue to meet the ICF-MR level of care, the LME is notified via phone or fax.
- Murdoch stamps each copy of the MR2 and maintains the white copy.
- Murdoch Center mails the original remaining stamped copies back to the LME.
- The LME will mail the blue, stamped copy of the MR2 to the appropriate DSS with a letter explaining that the individual is transitioning from an ICF-MR facility to the community. The pink, stamped copy of the MR2 is sent to the case manager. The LME will maintain a copy for their records.

2.4 Annual Re-evaluations of Level of Care

After initial evaluation, a re-evaluation of the LOC is completed annually during the individual's birthday month. Reevaluations are performed by a Qualified Professional, as defined in G. S. 122 C-3; 122C-25; 122C-26; 143-B-147. For the purposes of this waiver, a qualified professional refers to a qualified professional in the field of developmental disabilities. The following process for re-evaluation must be followed:

- A new MR2 is completed and signed by either the QDDP or a physician/licensed psychologist and the LME staff.
- The MR2 is typically signed during the birth month but may be signed no earlier than the month prior to the birth month.
- If ICF-MR level of care is questioned during this process, the individual may be referred back to the full evaluation process by the LME as outlined above to Murdoch Center for review of the MR2 and accompanying psychological.

2.5 Level of Care Determination by the LME

Beginning in July, 2006, LMEs that have demonstrated the ability to perform utilization review for the Medicaid State Plan services will be authorized to perform Level of Care determination for individuals referred for waiver funding in their catchment area. Clinical staff employed by the Division of MH/DD/SAS will continue to make the determination of level of care for individuals from catchment areas for which the LME has not been authorized to determine level of care. In both procedures, the results of the determination will be made on the MR2 form.

If LMEs that have demonstrated the ability to perform level of care determination establish that an individual does not meet the ICF-MR level of care, the LME will consult with clinical staff employed by the Division of MH/DD/SAS and/or the Chief of Clinical Policy. If after consultation it is maintained that the individual does not meet the ICF-MR level of care, a formal denial, including appeal rights is submitted to the individual/legally responsible person, with a copy to the case manager.

2.6 Denial and Appeal of ICF-MR Level of Care

2.6.1 Appeal of Level of Care Decisions

Murdoch Center clinical staff may determine that an individual does not meet the ICF-MR LOC. If the individual is denied by Murdoch Center, a case manager or the individual's physician or licensed psychologist may submit additional information to Murdoch Center on behalf of the individual. If Murdoch Center does not change the decision after reviewing the additional information, Murdoch Center staff will consult with the Division of MH/DD/SAS Chief of Clinical Policy prior to making a final decision. If, after consulting with the Division of

MH/DD/SAS Chief of Clinical Policy or his designee, Murdoch Center clinical staff determines that the individual does not meet the ICF-MR level of care Murdoch Center will send a formal denial via certified mail to the individual or legally responsible person. A copy is also sent to the case manager and the LME Service Authorization Unit and/or local approver. The denial will contain specific instructions for the individual to follow if he/she wants to request an appeal. The DMH/DD/SAS Appeals process should be followed.

2.6.2 Appeal of LOC Decisions for Continuing Eligibility

The LME lead agency may also question a person's continued eligibility for ICF-MR LOC while the person is receiving CAP-MR/DD funding, particularly at the time of the individual's Continued Need Review (CNR). Should this happen, the case manager informs the LME that level of care is being questioned and requests that the LME refer the individual to Murdoch Center clinical staff for eligibility determination. The individual/legally responsible person must be informed in writing by the case manager that the level of care is in question and will be referred to Murdoch Center.

A current MR2 with a physician or licensed psychologist's recommendation for the individual's level of care is submitted to Murdoch Center with current psychological evaluation information, including information about the individual's adaptive behavioral functioning. The MR2 is submitted with a letter explaining that the individual already has a prior approval number in the system so that the individual will not be issued a second number should Murdoch Center determine that the individual continues to meet the ICF-MR LOC. Murdoch Center reviews the MR2 and supporting documentation, and makes a decision about the individual's continued eligibility for CAP-MR/DD funding. If the individual is determined to no longer meet the ICF-MR LOC, the appeals process as noted above is followed by Murdoch Center staff.

SECTION 3. PERSON-CENTERED PLANNING

Person-centered planning is a means for people with disabilities or long-term care needs to exercise choice and responsibility in the development and implementation of their care plan. The individual directs the planning process that identifies strengths, capacities, desires and support needs. A person-centered plan generates action or positive steps that the person can take towards realizing a better and more complete life. Plans also are designed to ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to assess the quality of services being provided. ***For the CAP-MR/DD Waiver, the person-centered plan is called the Plan of Care.***

3.1 The Person Centered Planning Process

Once an individual is identified as needing CAP-MR/DD funding to provide services and supports and meets the LOC criteria, the case manager must initiate the person-centered planning process. Information gathered during the assessment, including Diagnostic Assessment, is used as the basis of the person-centered plan. The individual guides the planning process and chooses individuals to help them. Family members and friends are frequent contributors and the more traditional, professional service providers may also be included. Plans will incorporate varied supports, training, therapy, treatment and other services as needed to achieve the personal goals set by the individual. Plans draw upon diverse resources, mixing paid and natural supports to best meet the goals set.

The targeted case manager ensures that services, supports and treatment are planned for individuals and their families, as well as implemented in accordance with each individual's unique needs, expressed preferences and decisions concerning their life in the community. The person-centered planning process must ensure that the waiver's Plan of Care addresses all of the required elements of person-centered planning as identified in the DMH/DD/SAS person centered planning guidelines.[6] The Plan of Care format as shown in appendix C will record the results of the person-centered planning process and must include all elements noted in the person centered planning guidelines. All of the components of the Plan of Care format must be completed. The Plan of Care must specify not only waiver services to accomplish outcomes identified by the planning team, but also natural supports, community resources, and other paid supports available to meet the needs of the individual. In addition, the Plan of Care must clearly address needs related to health and safety as well and how they will be addressed. This includes crisis planning, both proactive and reactive, as well as identified back-up staff in case of emergencies.

[6] See DMH/DD/SAS Communication Bulletin #34, Person-centered Planning, March 21, 2005. You can find it on the Division's web site at: http://www.dhhs.state.nc.us/mhddsas/announce/index.htm.

3.2 Fair Hearing Process

Case managers must inform the individual or legal representative of the choice between CAP-MR/DD participation and ICF-MR placement. The case manager may do this at any point before the Plan of Care is submitted for approval to the LME service authorization unit or local approver. This choice is documented in the individual's Plan of Care. This statement must be signed annually at the time of the Continued Need Review.

Persons who are not given the choice of home and community-based services as an alternative to ICF-MR care or who are denied the service or provider of their choice are verbally notified of their right to a fair hearing. Each LME or designated lead agency will have in writing the appeal process at the local and state level, which contains at a minimum:

- The right to a fair hearing.
- The method for obtaining a fair hearing.
- The rules that govern representation at fair hearings.
- The right to file grievances and appeals.
- The requirements and timeframes for filing a grievance or appeal.
- The availability of assistance in the filing process.
- The toll-free numbers that the individuals can use to file a grievance and/or appeal by phone.
- Rights, procedures and timeframes for voicing or filing grievances and appeals or recommending changes in policy and services.

Each participant will receive a copy of their rights at the time of eligibility screening for home and community based waiver services. In addition, each participant will be notified of their appeal rights when denial, reduction or terminations of CAP-MR/DD services are made.

3.3 Completion of the Cost Summary

The cost summary must match all waiver services that are reflected in the Plan of Care and cover a twelve-month period. Only waiver services are required to be addressed on the cost summary. However, although only waiver services are required to be included on the cost summary, all identified services and supports to meet the needs of individuals must be clearly identified and addressed in the Plan of Care. This includes publicly funded services and supports and natural supports and community resources. This would include the specialized therapies and/or specialized equipment that the school system provides to a child.[7]

The cost summary also shown in appendix C is an automated document with drop down boxes to provide specific instructions for completion. In addition, the cost summary includes a help document to provide further direction and clarification on completion.

[7] Note that the LME is always the provider agency for Augmentative Communication, Home Modifications, Specialized Equipment and Supplies, Transportation and Vehicle Adaptations.

3.4 Initial Plan of Care approval Process

As noted above, the Plan of Care format will record the results of the person-centered planning process. The case manager must send the completed Plan of Care, the cost summary and all required documentation so that it is received by the LME service authorization unit or local approver no later than 60 days after the MR2 approval date or within the time frames in the Lead Agency Local Approval Plan if sooner than 60 days after the approval date. The Plan of Care must be signed by the individual or legally responsible person. For MR2s completed for individuals residing in ICF-MR group homes or mental retardation centers, the Plan of Care is completed no later than 60 days from the date the physician or licensed psychologist signs the MR2 or within time frames of the LME Lead Agency Local Approval Plan. If the plan is not received within the time limit, a new MR2 will have to be obtained and the process reinitiated.

3.5 Continued Need Review Approval Process

The case manager annually reassesses the individual's need for CAP-MR/DD funding by completing a Continued Need Review (CNR). The case manager completes a CNR to determine if the person continues to meet criteria for ICF-MR LOC and remains appropriate for CAP-MR/DD funding. The CNR is completed during the birth month of the individual. The NC-SNAP must also be updated during this time. The CNR must be completed and submitted to the LME service authorization unit or local approver no later than the fifth of the month following the CNR month, or the date of the LME Local Approval Plan, if sooner than the fifth of the month following the CNR month. *If the CNR is not completed and submitted on time, the person must be terminated from CAP-MR/DD.* Claims for services provided after the CNR month will be denied and may not be recouped.

The case manager is responsible for coordinating the evaluations and other information required for the CNR. This includes planning to be sure that the MR-2 and needed evaluations/updates are completed in a timely and cost-effective manner. A qualified professional (QP) with a Master's degree and one year of experience or a bachelor's degree and two years of experience with the developmental disability population or a physician or a licensed psychologist may sign the completed MR2 for CNR. It is usually signed during the person's birthday month but may be signed no earlier than the month prior to that month.

3.6 Revisions to the Plan of Care

Person-centered planning is a dynamic process and should contain review and revision of the plan as often as the individual's life circumstances change. The NC-SNAP should also be reviewed and updated whenever there is a change in the individual's situation.

Ongoing monitoring by the case manager, **including a minimum of one face to face contact per month,** may indicate a need for change in type, frequency, and duration of specific services as well as for CAP-MR/DD participation. **(The face to face contact must include a periodic**

visit to the home of the waiver recipient.) Actions required on revisions are explained below by type of revision.

3.6.1 Change in Cost

When the cost of a waiver service changes, the case manager recalculates the cost summary. Plan of Care approval through the LME service authorization unit or local approver is not required if only the cost of the service/support/equipment/supply changes.

3.6.2 Change in Amount, Duration or Frequency of Service

When a waiver service is to be added, deleted or changed in amount, duration, and/or frequency, the case manager revises the Plan except when the change is due to one of the following:

- A temporary, one-time change in approved services. Documentation should be made in the individual record to explain the circumstances of the change.
- Supply variations within the estimate. The amount used each month may vary from the estimate due to the different number of days in each month and minor changes in the individual's condition.

3.6.3 Preparing the Revision

The Plan of Care must be revised using the form designed for Plan Update/Revision, using the same instructions as the full plan. The cost summary reflects all of the waiver services for the individual for the entire waiver year. The initial Plan of Care shows what the individual is expected to receive. The revision reflects what the individual received prior to the effective date of the revision and what the individual will receive beginning on the effective date. Increases in CAP-MR/DD services, supports, and equipment, and supplies may not be approved retroactively.

- Terminating a service: When a service is stopped, the case manager lists the effective date of the cost revision and completes a cost summary showing all the entries from the last approved Plan of Care except for the waiver service that is being terminated. For the service being terminated:
  - Enter the new **TO** date for the service.
  - Show the **unit rate** previously approved.
  - Calculate the total cost of services for the individual's year to the new **TO** date; the automated cost summary will calculate this.
  - Divide the total by 12 or the number of months the individual is expected to receive CAP if it is less than a full year; the automated cost summary will calculate this.
  - Total the cost on the new summary.

- Adding a service: When a waiver service is added, the case manager lists the effective date of the cost revision and completes a cost summary showing all the entries as shown on the last approved Plan of Care **plus** the service that is being added.

- Changing a service: When a waiver service is changed during the individual's plan year, the effective date of the cost revision is listed and a cost summary revision is completed showing all the entries on the last approved Plan of Care **EXCEPT** for the waiver service that is being changed. The change is reflected by using two lines on the cost summary, one of the service as originally approved, changing the **TO** date, and recalculating. On the second line, the service as it is being revised is shown and calculated.

The minimum signature requirements for a revision are the individual /legally responsible person and the case manager. Revisions that involve an addition, deletion or change in frequency and/or duration of a CAP-MR/DD waiver service must be submitted to the LME service authorization unit or local approval for approval per the local approval plan. Minimum requirements for authorization of a revision include a Plan Update Form with the required signatures and a revised cost summary. Changes in goals/outcomes/objectives/strategies/supports alone do not require local approval unless required by the LME local approval plan.

3.6.4 Information Required for Plan of Care Approval

Minimum information submitted to the LME required for Plan of Care approval and authorization of services includes:

- Initial Plans of Care: Contact information for the case manager; and the Plan of Care, including Cost Summary; MR2, including LME, physician or licensed psychologist signature; and NC-SNAP.
- Continued Need Review (CNR): Contact information for the case manager; Plan of Care, including Cost Summary; MR2, including QP or physician or licensed psychologist signature; and NC-SNAP.
- Revisions: Contact information for the case manager; Plan of Care update page; and cost summary.

Evaluations may be needed or requested in some situations. Local approval plans must contain provisions for approvals required to meet the emergency needs of waiver recipients.

3.6.5 Utilization Review by the Service Authorization Unit of the LME

LMEs must adhere to standardized, statewide utilization review (UR) guidelines and process established by the Division of MH/DD/SAS in addition to the person-centered planning process, in order to insure that services authorized meet the needs of the individual.

The utilization review guidelines create two sets of service bands: one for individuals living in their own home or the family home, and one for individuals living in an alternative family living arrangement or licensed residential setting. Each band has four levels based on acuity of need. Acuity of need is established by the person-centered planning process and application of the NC-SNAP.

An index score is derived by multiplying the raw score of the SNAP times the overall domain score resulting from application of the SNAP. Based on the index score an individual may have a Level 1-4 of acuity. The LME service authorization unit or local approver is responsible for

applying the UR guidelines. Individuals whose level of acuity results in a budget in excess of $50,000 must have a second level clinical review at the LME level by a clinician identified by the LME. To insure that this review is completed in a timely manner, LME clinical staff must complete this second level review within three business days.

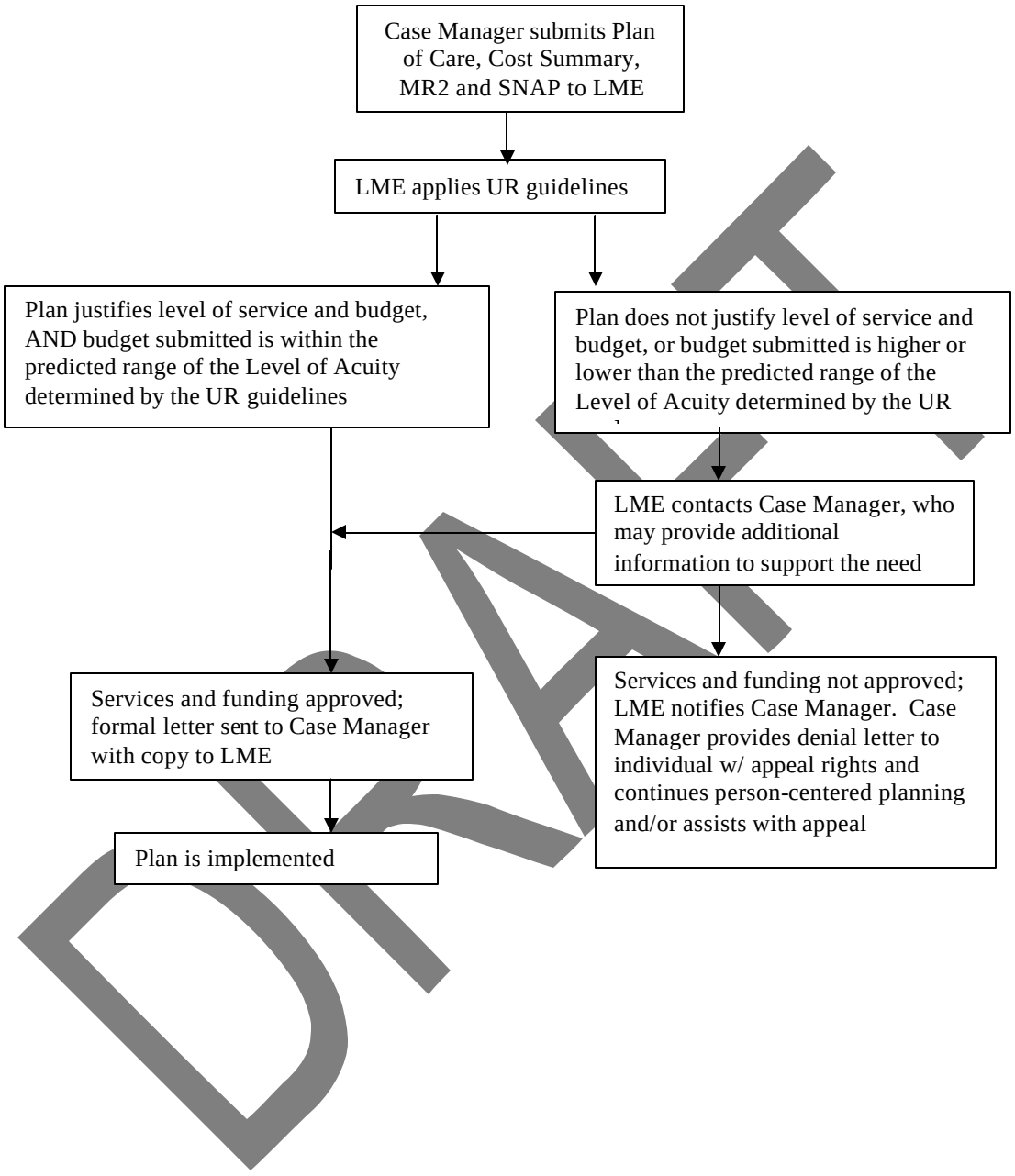
For budgets less than $85,000, in the event that an individual is determined to have a level of acuity either higher or lower than presented, the LME service authorization unit is responsible for contacting the case manager regarding the level of need. The case manager in collaboration with the individual/family will provide additional information to support a higher level of need or address health and safety if a lower level of need. If the LME does not change the decision after reviewing the additional information, the LME will send a formal denial to the individual or legally responsible person with a copy to the case manager along with their appeal rights if services are reduced. It is the responsibility of the case manager to work with the individual and/or legal representative to address and make changes in regard to individual needs and preferences in the person-centered Plan of Care.

Individuals whose level of acuity results in a budget in excess of $85,000 must have an additional review at the state level through the DMH/DD/SAS Chief of Clinical Policy or his designee at the Division of MH/DD/SAS. This is done by mailing the MR2, Plan of Care, cost summary and other appropriate documentation to the Division. The Chief of Clinical Policy or his designee will review the Plan of Care and cost summary within five working days. If services and accompanying funding is determined to be appropriate to address the needs and preferences of the individual based on diagnostic assessment and the person-centered planning process, a formal letter supporting the plan will be mailed to the LME with a copy to the case manager. If services and accompanying funding is determined to be in excess of what will meet the needs and preferences of the individual, a formal letter is sent to the LME service authorization unit or local approver with attached justification.

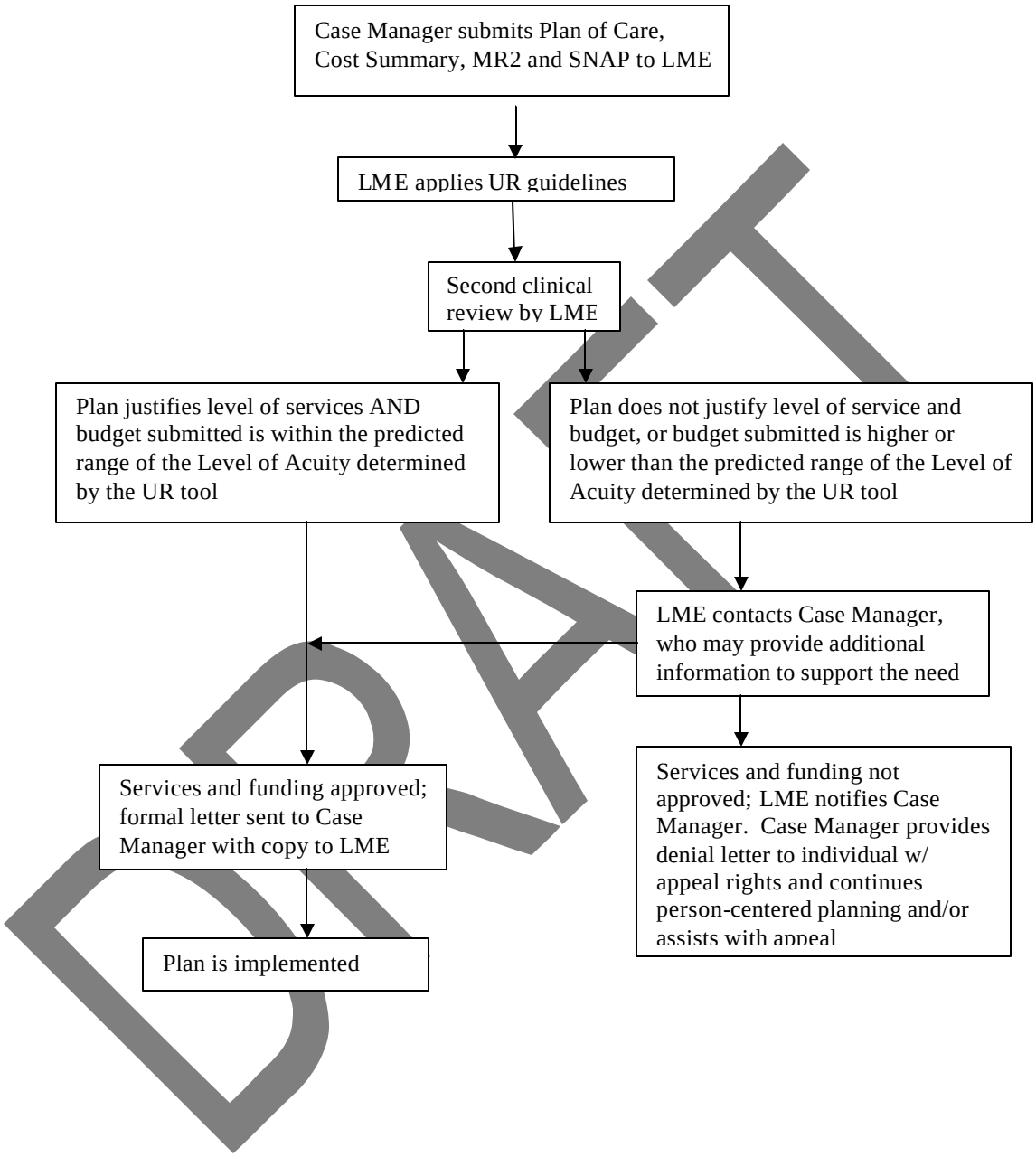
The case manager is responsible, in collaboration with the LME service authorization unit or local approver, to discuss the denial and continue with the person-centered planning process to determine needed adjustments to the plan. It is the also the responsibility of the case manager to provide a copy of the denial letter to the individual/legally responsible person along with their appeal rights.

It is the responsibility of both the LME Service Authorization Unit or local approver, as well as the case manager, to work in collaboration to ensure that activities noted above are completed within the timelines of the local approval plan.

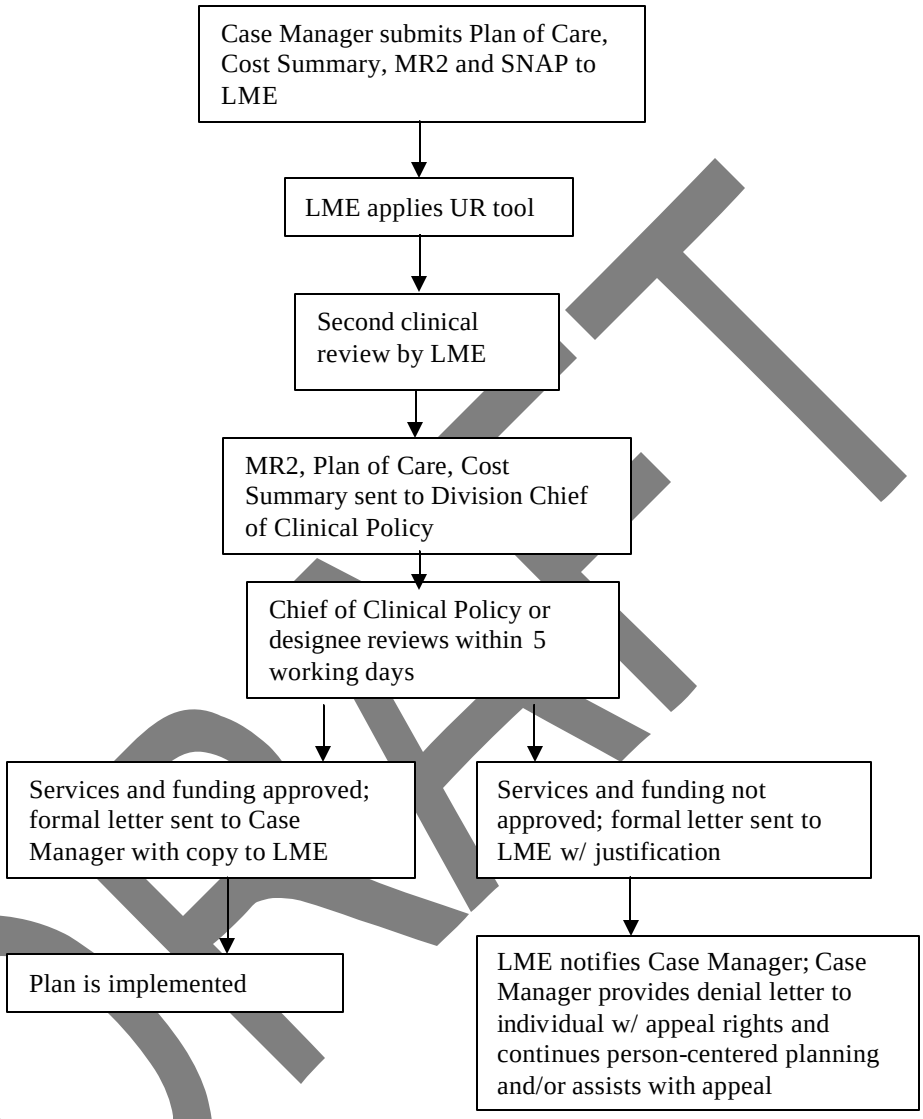
Utilization Review for Budget $50,000 or Less



Utilization Review for Budget between $50,001 and $85,000



Utilization Review for Budget $85,000 and above



3.6.6 Notification process for approval of initial Plans of Care, revisions or CNR

If the service authorization unit or local approver of the LME approves the Plan of Care, the LME shall:

- Notify the case manager in writing of the approval decision.

The case manager shall:

- Provide the individual/legally responsible person written notification of the approval, and a copy of the approved Plan of Care, including the cost summary.
- Provide written notification to the Department of Social Services (DSS) Medicaid staff of initial Plan of Care or CNR approval with a copy of the approval letter from the LME service authorization unit/local approver. For initial Plans of Care a copy of the cost summary must accompany the notification to DSS. If the individual has a Medicaid deductible, a copy of the Cost Summary must be included for a CNR as well as a revision.
- **It is the responsibility of the case manager for coordinating with DSS to insure that the CAP CM indicator has been entered onto the Medicaid card for individuals new to the waiver with an approved Plan of Care. The case manager is also responsible for reviewing the card monthly to insure that CAP eligibility continues.**
- Issue service orders and initiate services or any changes in services approved on the Plan of Care.
- Initiate or continue monitoring of services.

The Plan of Care is approved with the expectation that the services are going to be provided. Services are expected to be implemented within 45 days of Plan of Care approval.

3.6.7 Denial of Initial Plans of Care, Revisions or CNR

The service authorization unit or local approver of the LME decides whether to approve initial Plans of Care, revisions to the plan, and continued need reviews after all information is received. The LME notifies the case manager in writing of the decision, including reasons for denial if the Plan of Care, revision, or CNR is denied. The LME notifies the individual or responsible person in writing of the denial and individual's appeal rights. A copy of the notification should be sent to the case manager as well. The case manager notifies the DSS Income Maintenance staff of the denial once all appeal processes have been exhausted.

3.6.8 Service Authorization Staff

The LME is responsible for establishing and implementing the infrastructure that ensures compliance with all required timelines for authorization of Plan of Care activities.

- The LME maintains necessary staff that meet the requirements to perform service authorization functions for CAP-MR/DD recipients. The local approver must have at minimum a bachelor's degree in a human service field and a minimum of two years of postgraduate experience with the developmental disability population. Local approvers who also provide service authorization for Medicaid State Plan services must be a licensed, masters level clinician with experience in developmental disabilities. In addition, LMEs must ensure that individuals providing local approval/service

authorization for CAP-MR/DD services minimally demonstrate competency in the following areas:

- Person-centered planning.
- Authorization of specific waiver services.
- Application of the standardized, statewide utilization review guidelines and process established by the Division of MH/DD/SAS, and approved by the Division of Medical Assistance (DMA), in order to insure that services authorized meet the needs of the individual.

The LME is also responsible for determining how those competencies are met. This must be documented in the LME local approval plan.

3.6.9 Service Authorization

The Plan of Care approval process administered by the LME uses the standardized, statewide utilization review guidelines and process established by the Division of MH/DD/SAS to determine if the Plan of Care and revisions identify an array of supports needed to prevent institutionalization, promote independence and assure the health, safety and welfare of the individual. The local approval process also includes the utilization of the Plan of Care review checklists provided by the DMH/DD/SAS. The LME retains copies of the completed checklists as part of the approval process. Maximum timeframes for review of activities include fifteen working days for Initial Plans of Care, continued need reviews and cost revisions. The authorizer may request additional information from the case manager as long as the approval activity is completed within the designated timeframes.

The service authorizer or local approver makes all notifications to the case manager concerning all decisions regarding approval, denial or requests for additional information.

The LME will maintain an internal tracking system of all approvals, acknowledgements, and denials of Plans of Care. The tracking system must include at least the name of the person, the date that the activity requiring approval was received; the type of activity; the date of approval/denial of the activity; and the name of the authorizer. The tracking system must also meet any additional requirements in the local approval plan.

LME local approval plans must be updated as needed based on changes in policy by DMA or DMH/DD/SAS. Changes or updates to LME/Lead Agency local approval plans must be documented and approved through the local LME process; i.e. review and approval of Board. Changes to local approval plans will be monitored and reviewed by Program Accountability as part of lead agency functions during bi-annual monitoring of local approval and/or annual audits.

3.6.10 Monitoring of LME lead agency CAP-MR/DD local approval/service authorization process

Staff from the DMH/DD/SAS Accountability Team will monitor local approval authorization by the LME at least bi-annually (every 6 months) at the discretion of the local approval consultant. Five percent of active CAP-MR/DD records in each area authority/LME (up to 15 records) will be reviewed with initial plans, CNRs and cost revisions. The review will consist of a sample of

activities approved locally during the three-month period prior to the monitoring visit. The team member may ask to review the activity log and note any issues regarding local approval timelines. The team member will review each activity, using the checklist for plans of care/services. The team member will review the infrastructure system for minimum local approval requirements based on the LME/Lead Agency policy. Team members will require a plan of correction for any plan with deficiencies in the MR2 and/or case management signature page sections of the checklist for plans of care. The team member may require formal follow up or a plan of correction for items contained in the plan of care, attachment or cost summary sections of the checklist should two or more plans contain errors on the same item of the checklist.

The LME is given copies of review tools and report findings at the close of the monitoring session. It is up to the designated representative of the LME to disseminate results of the monitoring including follow up and formal plan of correction within the LME. Formal follow up plans will be submitted to the team member within 10 working days of monitoring visit. The team member will contact the LME of acceptance or rejection of the formal follow up plan within 10 working days of receiving plan. Formal plans of correction will be submitted within 15 working days of monitoring visit. Formal plans of correction will be copied to the Accountability Team Leader. The team member will contact the LME of acceptance or rejection of the formal plan of correction, copying the Accountability Team leader within 15 working days of receiving the plan. The team member will monitor the implementation of corrective actions on the next scheduled/unscheduled-monitoring visit. Serious issues with local approval will result in referral to DMH/DD/SAS team and/or DMA. Local approval may be suspended temporarily upon the request of the LME, by the Director of DMH/DD/SAS, or the Director of DMA. Local approval may be terminated following unsuccessful attempts to bring the LME into compliance with local approval regulations. If this happens, the Secretary of DHHS will reassign the Lead Agency for the LME.

In addition to the above, the consultant will also monitor application of the UR guidelines. This will be done through review of complaints, grievances or appeals in regard to application of the guidelines. An unusual amount of complaints, grievances, or appeals resulting from application of the guidelines will require consultation to the LME service authorization regarding appropriate use of the tool. Continued misapplication of the guidelines could result in revocation of Plan of Care approval by the LME and reassignment of this Lead Agency function.

SECTION 4. SERVICES AND STANDARDS

4.1 General Guidelines

Unless otherwise noted, all services under this waiver are secondary to services available under the Medicaid State Plan under Title XIX.[8] If the services and supports needed by a waiver recipient are reimbursable under the Medicaid State Plan, the Medicaid State Plan services shall be authorized; waiver services shall only be authorized when the services and supports needed are not reimbursable under the State Plan or have been otherwise excluded by the State Plan Service Definitions.

Amount and duration of services provided are determined through the person-centered planning process with the individual's planning team. Services are based on the needs and preferences of the individual, the availability of other formal and informal supports, and rules of the funding source.

Waiver services to be delivered out of state are subject to the same requirements as services delivered out of state under the State Plan, in accordance with 42 CFR 431.62.

All CAP-MR/DD services are to be provided with a staffing ratio of one direct service employee to the person unless defined differently by the service definition or unless the service is provided in accordance with a group rate and meets the needs of the individuals as identified in the person-centered plan. If an individual normally receives a group rate, then that rate must be billed regardless of the attendance of the other individuals in the group.

All CAP-MR/DD services may be billed only by an agency enrolled with DMA and endorsed by the LME to provide the specific service. Providers must meet the endorsement process as specified in *Communication Bulletin # 37, Policy and Procedures for Provider Endorsement.*

CAP-MR/DD may not be provided at school; CAP-MR/DD services are not offered during the school day while a child is attending school. The exceptional student's school day is the same as the students in general education unless otherwise specified in the Individualized Education Plan (IEP). If the child's IEP indicates that the child's school day is less than that of other children, the child may receive non-habilitative CAP-MR/DD services during the normal operating hours of the local Lead Education agency.

For children who are receiving home schooling, the family will provide the home schooling enrollment certificate to the case manager and a schedule of dates/hours of operation of the home school. If the child's home schooling schedule indicates that the child's school day is less than that of other children in the school system, the child may receive non-habilitative CAP-MR/DD services during the normal operating hours of the local Lead Education agency.

[8] North Carolina's Medicaid State Plan is on the following web page: http://www.dhhs.state.nc.us/dma/publications.htm

For the purposes of the CAP-MR/DD waiver, an Alternative Family Living Home or Adult Foster Home for one person is provided as an out of home placement for a person who chooses this setting or whose family cannot provide care for that person. The individual receives 24-hour care from and lives in a private home with a family in a home environment where the services are for the care and/or habilitation of the individual. The home does not require a license because it serves only one adult with a developmental disability. The LME and CAP-MR/DD case manager jointly monitor the health and safety of the person. CAP-MR/DD services may not be utilized as payment for room and board costs.

4.2 Out of State Policy

For individuals living in counties bordering another state, services may be provided by an enrolled CAP-MR/DD provider agency that is within 40 miles of the border of the county.

These guidelines are to be used when families/individuals are traveling out of state:

- Services are for individuals who have been receiving services from direct care staff while in state and who are unable to travel without their assistance.
- These guidelines only apply to individuals who do not live in residential facilities.
- Provider agencies employing staff who would be involved in this process must give written prior approval of this request for their staff to accompany families/individuals out of state.
- Provider agencies must ensure staffing needs of all their clients can be met.
- Provider agencies must continue to provide supervision and monitoring of care.
- Treatment plans must not be changed to increase services while out of state.
- Services can only be reimbursed to the extent they were provided within the state's boundaries and for the benefit of the individual.
- Respite services are not provided during out of state travel since the caregiver is present during the trip.
- If licensed professionals are involved, Medicaid cannot waive other state's licensure laws. A North Carolina licensed professional may or may not be licensed to practice in another state.
- Medicaid will not be responsible for room, board, or transportation cost.
- Provider agencies assume all liability for their staff when out of state.
- Individuals living in alternative family living settings may receive services when traveling out of state with their alternative living family.

4.3 Choice of Providers

Individuals who receive CAP-MR/DD funding must be offered choice in the selection of provider agencies. Provider agencies of the Medicaid State Plan service of targeted case management, including their subsidiary corporations, related partners, or closely allied entities, may not provide targeted case management services and waiver services to the same person.

Provider agencies that provide targeted case management must establish or adopt policies to assure that all good faith efforts are made to inform individuals of the full array of provider choices. Provider agencies may not ask individuals or their legally responsible representatives to sign long term contracts, participation agreements or any other document that specifies any other condition or participation that would restrict the individual's right to choose a different provider agency. **Provider agencies may not provide incentives such as gifts or an expectation of "savings" within a budget in order to attract any individual or their legally responsible representative to enroll with their agency.**

4.4 Waiver Services Furnished by Family Members

Natural supports are identified as places, things and, particularly, people who are a part of our interdependent lives and whose relationships are reciprocal in nature and often vital to a consumer's welfare. Person centered planning promotes the concept that purchased or funded supports should not supplant natural resources available to the individual when they are available and appropriate to the need of the individual. With this in mind, the following guidelines are provided for waiver services furnished by family members:

- Waiver services cannot be provided to recipients by legally responsible relatives, i.e. spouse or parent/step-parents. In addition, these individuals cannot own or operate the provider agency providing services to their minor children/step-children or spouse. Medicaid payment may be made to **qualified** parents of minor children or to spouses for **extraordinary** services requiring specialized skills for which the parent or spouse are not legally obligated to provide. These specialized skills include such services as skilled nursing, physical therapy, etc.

- Waiver services may be provided by relatives, including parents of adult children, if there is justification as to why the relative is the provider of care and meets the qualifications for providers of care. Payments may only be made to relatives if:
    - the relative meets the provider qualifications for the service;
    - payment is made only in return for specific waiver services rendered as identified in the person centered Plan of Care
    - there is justification as to why the relative is the provider of services; i.e., lack of alternative providers, or special circumstances or considerations associated in caring for the individual noted in the Plan of Care
      -the LME local approver will serve as a third party in review of the justification for provision of services by a family member, and will make the final decision as to whether it is in the best of interest of the individual for the family member to provide the service based on information outlined in the Plan of Care

4.5 Waiver Services Furnished by Legal Guardians

- Legal *guardians of the person* may provide waiver services to individuals since they are not financially responsible for the individual. (Information regarding Guardianship may be found in G.S. 35A-1202 (10).) In order to address the potential conflict of interest of legal guardians in the role of decision maker for the ward also providing waiver services, the following protocols must be followed:

    - There is clear justification as to why the legal guardian is the provider of services, i.e., lack of alternative providers or special circumstances or considerations associated in caring for the individual noted in the Plan of Care.

    - The LME local approver will serve as a third party in review of the justification for provision of services by a legal guardian and will make the final decision as to whether it is in the best of interest of the individual for the legal guardian to provide the service based on information outlined in the Plan of Care.

    - The legal guardian must meet the provider qualifications for the service.

4.6 Services

The following describes services paid for through the CAP-MR/DD waiver. For each service there is a description of the service, requirements and any limitations. The requirements for documentation of the above noted services may be found in the Division of MH/DD/SAS Service Records Manual.

For the purposes of the CAP-MR/DD waiver, an Alternative Family Living Home or Adult Foster Home for one person is provided as an out of home placement for a person who chooses this setting or whose family cannot provide care for that person. The individual receives 24-hour care from and lives in a private home with a family in a home environment where the services are for the care and/or habilitation of the individual. The home does not require a license because it serves only one adult with a developmental disability. The LME and CAP-MR/DD case manager jointly monitor the health and safety of the person. CAP-MR/DD services may not be utilized as payment for room and board costs.

4.6.1 Targeted Case Management

Targeted case management services are a required service for individuals participating in this waiver. Targeted case management is a Medicaid State Plan service. Provider agencies, including their subsidiary corporations, related partners, or closely allied entities, may not provide targeted case management services and waiver services to the same person.

The intent of targeted case management is to promote consumer choice by broadening the provider base. It also assists the state in establishing a coordinated service system that, when appropriate, makes movement of individuals into the waiver a smooth process.

Case managers provide a variety of functions to individuals receiving waiver funding. Case management involves locating, obtaining, coordinating and monitoring social, habilitative and medical services as well as other services and supports related to maintaining an individual's health, safety and well-being in the community. Primary responsibilities include:

- Obtaining input from the individual/providers/significant others about the service delivery process and seeking information in an effort to obtain needed services/supports on behalf of the individual.

- Facilitating person-centered planning, circle of friends, planning teams, revising the Plan as needed and submitting the plan for LME authorization.

- Informing significant others about the individual's situation and the case manager's efforts on behalf of the individuals with consent of the individual/legally responsible person.

- Locating and coordinating sources of help so that the individual receives available natural and community supports.

- Completing application forms to assist in receiving community and other formal service support.

- Facilitating the service delivery process, including CAP-MR/DD, beginning with intake/initial assessment and including the identification and procurement of services, on going monitoring of care and services, and the annual re-evaluation of the individual's needs and services.

- Monitoring the individual's situation to assure quality care as well as the continued appropriateness of services.

Individuals that provide case management must meet the following requirements:

- A master's degree in a human service area with one year of experience with the population served; or
- A bachelor's degree in a human service area with two years of experience with the population served.

4.6.2 Adult Day Health

Adult day health services is a service furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regiment" (3 meals per day). Services are provided in a certified adult day health care facility.

This service is for adults who are aged, disabled, and handicapped that need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting for the purpose of supporting an adult's independence, and promoting social, physical, and emotional well being. Services must include health services and a variety of program activities designed to meet the individual needs and interests.

The cost of transportation is not included in the rate paid to providers of adult day health services.

Limitations: This service may not be provided at the same time of day that a person receives:

Home and Community Supports
Individual and Caregiver Training
Personal Care Services
Residential Supports
Respite Care
Specialized Consultative Therapy
Supported Employment
Transportation

It may not be provided on the same day as Day Supports.

4.6.3 Augmentative Communication

Augmentative communication devices are necessary when normal speech is non-functional and/or when physical impairments make a gestural system impossible and/or ineffective. An aided system requires access to a symbolic system that is separate from the body. Selection of devices (and training outcomes for those devices) must be specific and based on age, cognitive ability, fine and gross mobility, environmental need and presence or absence of sensory impairment. These devices are recommended by a speech/language pathologist licensed to practice in the State of North Carolina and documented in the Plan of Care as necessary to meet the needs of the individual. The Plan also specifies who and how the individual and/or his/her family/caregiver will be trained on the use of the equipment.

This service also covers technical assistance provided to individuals in the selection of augmentative communication devices by qualified augmentative communication technology professionals. This assistance may not duplicate evaluation and services provided by licensed speech, occupational, and/or physical therapists. Technical assistance in the selection of augmentative communication devices will be billed through the LME under the Aug Com definition. Service and repair of purchased equipment is included when not covered by warranty.

The hardware and software needed to augment communication is divided into the following categories:

- Low technology and clinician made devices.
- High technology, commercially available dedicated devices and systems.
- Standard computer/monitors and operating peripherals.
- Computer-driven devices, operating peripherals and printers.
- Mounting kits and accessories for each component.
- Overlay kits and accessories.
- Switches/pointers/access equipment—all types, standard and specialized.
- Keyboard/voice emulators/key guards.
- Voice synthesizers.
- Carry cases.
- Supplies (battery, battery charger).
- Artificial larynges.

Service Limitations:

- The cost of augmentative communication devices shall not exceed $10,000 per waiver year per person.
- Augmentative communication devices cannot be purchased for use in the school system.
- The service may not be used to purchase cameras.

4.6.4 Crisis Services

Crisis services provide one additional staff support person for supervision for the CAP-MR/DD waiver recipient, as needed during an acute crisis situation so that the recipient can continue to participate in his/her daily routine and/or residential setting without interruption. It is appropriate to provide such support during periods of time in which the person is presenting episodes of unmanageable and/or inappropriate behaviors that require specialized staff intervention. An individual may display extreme, maladaptive behaviors that are not anticipated, are temporary in nature, and are beyond the daily behaviors that are addressed through other supports. Crises of this nature may be due to medication changes, reaction to family stress, or other trauma. By providing this service, an imminent institutional admission may be avoided while protecting the person from harming themselves(s) or others.

While receiving this service, the person is able to remain in his/her place of residence, in the day program, or in respite care, while a crisis plan is developed and implemented. Crisis Services staff will implement intervention plans that are directed at reducing the maladaptive behavior. This service is only offered in the setting(s) where the person receives services.

Crisis services are provided for periods of up to 14 consecutive days per episode. An initial order for the service may be approved by the case manager with approval or denial of the service authorization by the LME/area authority/county program within 3 days of service inception. Following any first use of crisis stabilization services, the individual's Plan of Care will be reviewed and updated to reflect a plan for prevention and interventions of subsequent occurrences. The Plan of Care must identify crisis early warning signals, triggers, and the necessary services and supports to insure the health and safety of the individual. Any plan that involves the use of restrictive interventions will be written by a psychologist or psychiatrist and approved by the client rights committee.

Service Limitations:

- An individual may not receive over 2,016 hours per waiver year per person.

4.6.5 Day Supports

Day supports provide assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills, which take place in a non-residential setting, separate from the home or facility in which the individual resides.

Day supports shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the plan of care. In addition, habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

This service meets the day programming needs of individuals who choose to attend or receive services provided by a licensed facility, such as an adult day vocational program (ADVP) or Developmental Day. Community activities that originate from a licensed day facility will be provided and billed as day supports. On site attendance at the licensed facility is not required to receive services that originate from the facility. This provides the opportunity for individuals who attend or receive services provided by a licensed facility to receive some or all of their habilitation in the community.

Service Limitation: This service may only be provided by a licensed day facility and is inclusive of transportation to and from the participant's primary residence, the licensed day facility, and/or the community. Travel time is not actual service time and therefore actual billing for the service begins after the person reaches the site; the travel time is addressed through the rate established for the service definition.

Limitations: This service may not be provided at the same time of day that a person receives:

Home and Community Supports
Individual and Caregiver Training
Personal Care Services
Respite Care
Residential Supports
Specialized Consultative Services
Supported Employment
Transportation

or one of the regular Medicaid services that works directly with the person, such as Personal Care Services, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

It may not be provided on the same day as Adult Day Health.

4.6.6 Home and Community Supports

The intent of this service is to meet the habilitation and support needs of individuals living in their own home or their family's home.

Home and community supports services provide instruction and assistance to enable the individual to acquire and maintain skills that will allow him/her to function with greater independence in the community. Home and community supports provides habilitation, training and instruction coupled with elements of support, supervision and engaging participation to reflect the natural flow of training, practice of skills, and other activities as they occur during the course of the person's day. Interactions with the person are designed to achieve outcomes identified in the Plan of Care. Support and supervision of the person's activities to sustain skills gained through habilitation and training is also an acceptable goal of home and community Supports. This service may be provided in an individual's private residence and/or in the community.

Home and community supports consist of an integrated array of individually designed services and supports that are described in the Plan of Care. This service is distinctive from personal care cervices by the presence of training activities in addition to support, supervision, and monitoring as described in the Plan of Care.

Home and Community Supports include:

- Training and/or support with socialization that includes development or maintenance of self-awareness and self-control, social responsiveness, social amenities, and interpersonal skills, and the development and maintenance of personal relationships.

- Training and/or support with personal skill development that includes activities designated to improve the participants' own ability to accomplish every day activities of community living, including eating, bathing, dressing, personal hygiene, and mobility.

- Training and support with community participation, recreation, or leisure that includes the development or maintenance of skills to use community resources, facilities or businesses and support in accessing such opportunities for community integration.

Service Limitations: Individuals who live in licensed residential settings or unlicensed alternative family living arrangements may only receive the community component of this service. **However, it should be noted that the Residential Support definition also includes the ability to provide training and habilitation and support in the community for activities such as shopping, access to transportation, etc. that are related to home living.**

Therefore, the community component of Home and Community Supports does not replace the Residential Support provider's responsibility to provide support to individuals in the community, but is intended to support those who choose to engage in community activities that are not provided through a licensed day program. Community activities such as shopping, going to the park, etc. are the responsibility of the Residential Supports provider.

This service may not be provided at the same time of day as:

Adult Day Health
Day Supports
Personal Care
Respite
Supported Employment
Specialized Consultative Therapy
Transportation
Individual and Caregiver Training

4.6.7 Home Modifications

Home modifications includes equipment and physical adaptations to the individual's home that are required by his/her needs as documented in the Plan of Care, as necessary to ensure the health, safety and welfare of the person; enable the person to function with greater independence in the home; and are of direct and specific benefit due to the person's disability. Home modifications are cost effective compared to the provision of other services that would be required in an inaccessible environment. The service will reimburse the purchase, installation, maintenance and repair of Home Modifications. Repairs are covered when the cost is efficient compared to the cost of the replacement of the item only after coverage of the warranty is explored.

Home modifications will only be provided when the modification is necessary to meet the needs of the person and prevents institutionalization. All services shall be provided in accordance with state or local building codes and Americans with Disabilities Act (ADA) requirements.

Home modifications include:

- Installation, maintenance and repairs of ramps, grab bars and handrails as well as portable ramps.
- Widening of doorways/passageways for handicap accessibility.
- Modification of bathroom facilities including handicap toilet, shower/tub modified for physically involved persons, sink modifications, toilet modifications, water faucet controls, floor urinal adaptations, plumbing modifications, and turnaround space modifications.
- Bedroom modifications to accommodate hospital beds and/or wheelchairs.
- Thermostats, shelves, closets, sinks, counters, cabinets and doorknobs.
- Shatterproof windows.
- Floor coverings for ease of ambulation.
- Modifications to meet egress regulations.
- Alarm systems/alert systems including auditory, vibratory, and visual to ensure the health, safety, and welfare of the person (includes signaling devices for persons with hearing and vision loss).
- Fences to ensure the health, safety and welfare of an ambulatory waiver recipient who lives in a private home and does not receive paid supervision for 10 hours per day or more.
- Video cameras to ensure the health, safety, and welfare of a wavier recipient who must be visually monitored while sleeping for medical reasons, and who resides in a private home without paid supervision during sleep hours.
- Porch or stair lifts.
- Hydraulic, manual, or electronic lifts, including portable lifts or lift systems that could be removed and taken to a new location that are used inside the individual's home.
- Stationary/built in therapeutic table.
- Weather protective modifications.
- Fire safety adaptations.

Service Limitations:

- Modifications that add to the total square footage of the home are excluded from this benefit.
- Home modifications can only be provided in the following settings:
  1. Dwelling where the waiver recipient resides that is owned by the individual or the family.
  2. In rented residences when the modifications are portable.
- This service cannot be used to purchase locks.
- The total cost of Home Modifications cannot exceed $15,000 over the duration of this waiver (3 years).

It is the responsibility of the case manager to track the cost of Home Modifications billed and paid for during a plan year, in order not to exceed the total amount of $15,000 over 3 years. Costs that were not paid during one waiver year must be added to the cost summary for the next waiver year.

The service reimburses for the purchase, installation, maintenance, and repair of environmental modifications and equipment. Repairs are covered when the cost is efficient compared to the cost of the replacement of the item.

Home modifications can only be provided as a waiver service when they are documented in the Plan of Care as necessary to meet the needs of the recipient, prevent institutionalization and payment is not available as part of a Medicaid state plan option.

4.6.8 Individual/Caregiver Training and Education

Individual/caregiver training and education includes training and counseling services for the individual and or family members of the individual. The purpose of this service is to enhance the decision making capacity of the family unit, provide orientation regarding the nature and impact of the developmental disability upon the individual and his/her family, provide information about community integration options and strategies, provide education and training on intervention strategies, and provide education and training on the use of specialized equipment and supplies. Updates are included to maintain the person safely at home.

For purpose of this service "family" is defined as the people who live with or provide care to the person receiving waiver services, and may include a parent, spouse, children, relatives, foster family, guardians or in-laws. "Family" does not include individuals who are employed to care for the person. All family training will include outcomes that are documented in the person's Plan of Care. The service includes conference registration, and enrollment fees for classes. Travel to conferences will be reimbursed for waiver participants only.

Service Limitations:

- Individual/Caregiver Training and Education excludes training furnished to family members though Specialized Consultative Services.
- The service is limited to a maximum expenditure of $1500 per waiver year per person which includes a maximum of $1000 for conference registration, travel to conferences for waiver participants, and enrollment fees for classes.
- Individuals who are paid service providers are excluded from this service.

This service may not be provided at the same time of day as:

Adult Day Health
Day supports
Home and Community Supports
Personal Care
Respite
Residential Supports
Supported Employment
Specialized Consultative Therapy

4.6.9 Personal Care Services

Personal Care services include support, supervision and engaging participation with eating, bathing, dressing, personal hygiene and other activities of daily living. Support and engaging consumer participation is non-habilitative and describes the flexibility of activities that may encourage the person to maintain skills gained during active treatment and/or habilitation while also providing supervision for independent activities of the consumer. This service may include assistance with preparation of meals, but does not include the cost of the meals themselves.

When specified in the Plan of Care, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family. Personal Care also includes assistance with monitoring health status and physical condition, assistance with transferring, ambulation and use of special mobility devices.

Personal care providers may be members of the individual's family; however, payment will not be made for services furnished to a minor by the child's parent (or stepparent), or to an individual by that person's spouse. Family members or legal guardians who provide personal care services must meet the same standards as providers who are unrelated to the individual. Legal guardians of the person may provide waiver services to individuals since they are not financially responsible for the individual. (See sections 4.4 and 4.5 above for information regarding family members and guardians as providers.)

Supervision of personal care providers will be furnished by a registered nurse if the service is provided through a home health agency, or by a qualified professional (QP) or associate professional (AP) when provided by an LME or certified private provider agency as specified in provider qualifications. Frequency or intensity of supervision is clearly indicated in the Plan of Care.

Service Limitations:

- Personal Care services do not include medical transportation and may not be provided during medical transportation and medical appointments; and
- Individual who live in licensed residential facilities, licensed alternative family living (AFL) homes, licensed foster care homes or unlicensed alternative family living homes serving one adult may not receive this service. See Glossary for AFL definition. (See Glossary for definition of AFL)

Limitations: This service may not be provided on the same day that the person receives regular Medicaid Personal Care Services, a Home Health Aide visit, or another substantially equivalent service. This service may not be provided at the same time of day that a person receives:

- Adult Day Health
- Day Supports
- Home and Community Supports
- Individual and Caregiver Training
- Specialized Consultative Therapy

- Respite Care
- Supported Employment
- Transportation

4.6.10 Enhanced Personal Care

Enhanced Personal Care is intended for individuals receiving waiver funding who have intense medical or behavioral needs. It is not a habilitative service but includes the same activities and functions as Personal Care Services. Such intense medical or behavioral needs must be identified by the NC-SNAP and the person-centered Plan of Care must provide clear documentation and justification of the need for enhanced personal care. The results of the application of the NC-SNAP must result in a SNAP index score that places them in a level 3 or 4 of the statewide Utilization Review guidelines. However, having a SNAP index score that places a person in a level 3 or 4 will not automatically require enhanced personal care. There must clear justification outlined within the Plan of Care. Additional training requirements for direct care staff providing the service must be documented in the Plan of Care.

Limitations for Enhanced Personal Care are the same as those listed under Personal Care above.

4.6.11 Personal Emergency Response System (PERS)

PERS is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified in Provider Qualifications. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, who are alone for any period of time and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

4.6.12 Residential Supports

The intent of this service is to meet the habilitation and personal care needs of individuals living in licensed residential settings or unlicensed alternative family living homes. It was designed to provide flexibility and reflect the natural flow of a person's day.

Residential Supports provide assistance with acquisition, retention, or improvement in skills related to activities of daily living, such as personal grooming and cleanliness, bed making and household chores, eating and the preparation of food, and the social and adaptive skills necessary to enable the individual to reside in a non-institutional setting. Habilitation, training and instruction are coupled with elements of support, supervision and engaging participation to reflect the natural flow of training, practice of skills, and other activities as they occur during the course of the person's day. This service is distinctive in that it includes habilitation and training activities, as well as care and assistance with activities of daily living when the individual is dependent on others to ensure health and safety. Interactions with the person are designed to achieve outcomes identified in the Plan of Care. Support and supervision of the person's activities to sustain skills gained through habilitation and training are also acceptable goals of Residential Supports.

This service is provided to individuals who live in licensed community residential settings, foster homes, or alternative family living homes as well as unlicensed alternative family living homes that serve one adult. (See Glossary for definition of AFL.) This service also provides assistance, support, supervision, and monitoring that allow individuals to participate in home or community activities. Individuals living in licensed settings may use this service to provide habilitation and support in community living activities such as shopping and leisure activities in the community.

Service Limitations:

- Payments for Residential Supports are not made for room and board.
- Payments for Residential Supports do not include payments made, directly or indirectly, to members of the individual's immediate family. For the purpose of this waiver, immediate family means parent or stepparent of a minor child, or spouse.
- Payments will not be made for the routine care and supervision that would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.
- Residential Supports can be provided in licensed residential settings of 8 beds or less including licensed Alternative Family Living or Foster Homes and unlicensed alternative family living homes serving one adult. With additional justification, individuals living in licensed settings of greater than 8 beds may receive residential supports. Additional justification will include identification and documentation in the Plan of Care of the unique circumstances that would require the individual to live in a setting larger than 8 beds and documentation that all options were provided to the individual/family during the person-centered planning process. Individuals who live in licensed group homes or adult care homes with more than 8 beds and who were participating in the CAP-MR/DD waiver (North Carolina's approved 1915-C Home and Community Based Waiver) at the time of the implementation of this waiver may also receive Residential Supports.

- Individuals who receive Residential Supports may not receive State Plan Adult Care Personal Care Services or waiver Personal Care Services since personal care components are included within the definition.

Limitations: Residential Supports may not be provided at the same time of day that a person receives:

- Adult Day Health
- Day Supports
- The Community component of Home and Community Supports
- Respite
- Supported Employment
- Transportation

The community component of Home and Community Supports may be used with Residential Supports only in order to meet the day programming needs of individuals who have chosen not to receive their day programming needs through a licensed facility.

4.6.13 Respite

Respite care is a service that provides periodic relief for the family or primary caregiver. In order to be considered the primary care giver, a person must be principally responsible for the care and supervision of the individual, and must maintain their primary residence at the same address as the covered individual. This service may be provided in the individual's home or in an out-of-home setting.

Respite should not be provided to an individual when the individual is home for the purpose of a family visit.

Service Limitations:

- Private home respite services serving individuals outside their private homes are subject to licensure under G.S. 122C Article 2 when:
  1. more than two individuals are served concurrently, or
  2. either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month;
- Respite service may not be used as a daily service;
- Respite services may not be provided for individuals living in licensed group homes or adult care homes;
- Respite services may not be used for individuals who are living alone or with a roommate;
- Staff sleep time is not reimbursable;
- Respite services are only provided for the individual; other family members, such as siblings of the individual may not receive care or supervision from the provider while Respite Care is being provided/billed for the individual;
- Respite is not provided by any person who resides in the individual's primary place of residence;
- The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-MR Facility; and
- Federal Financial Participation (FFP) will not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved by the State that is not a private residence.
- Respite will be provided in the following locations:
  - Individual's home or place of residence.
  - Foster home.
  - Licensed respite facility.
  - Other community care residential facility approved by the State that is not a private residence including:
    - Alternative family living arrangement.
    - Certified respite provider's home.
    - State Regional Mental Retardation facility.

Limitations: This service may not be provided at the same time of day that a person receives:

- Adult Day Health

- Day Supports
- Home and Community Supports
- Individual and Caregiver Training
- Personal Care
- Residential Supports
- Supported Employment
- Transportation

- Or one of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services, or individual therapies.

4.6.14 Enhanced Respite Care

Enhanced Respite Care is intended for individuals receiving waiver funding who have intense medical or behavioral needs. It is not a habilitative service and includes the same activities and functions as Respite. Such intense medical or behavioral needs must be identified by the NC-SNAP and the person-centered Plan of Care must provide clear documentation and justification of the need for enhanced personal care. The results of the application of the NC-SNAP must result in a SNAP index score that places them in a level 3 or 4 of the statewide Utilization Review guidelines. . However, having a SNAP index score that places a person in a level 3 or 4 will not automatically require enhanced respite. There must clear justification outlined within the Plan of Care. Additional training requirements for direct care staff must be clearly documented in the Plan of Care.

4.6.15 Respite Care-Institutional

This is respite provided in an ICF-MR bed in a State regional MR facility. This type of respite is generally used when community-based services are not available to care for the person. Other CAP-MR/DD services may not be billed on the day of admission to the institutional respite facility but may be billed on the day of discharge.

4.6.16 Respite Care-Non-Institutional Nursing-Based

A registered nurse (RN) or licensed practical nurse (LPN) provides this level of respite in a private home.

4.6.17 Specialized Consultative Services

Specialized Consultative Services provides expertise, training, and technical assistance in a specialty area (psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy, physical therapy, or nutrition) to assist family members, caregivers, and other direct service employees in supporting individuals with developmental disabilities who have long term habilitative treatment needs. Under this model, family members and other paid/unpaid caregivers are trained by a licensed professional to carry out therapeutic interventions, which will provide consistency and increase the effectiveness of the specialized therapy. This service is also utilized to cover the cost of specialists identified as an integral part of the treatment team to participate in team meetings and provide additional intensive consultation and support for individuals whose medical and/or behavioral psychiatric needs are considered to be extreme or complex. The need for Specialized Consultative Services must be clearly reflected on the individual's Plan of Care.

The activities below are *not* covered under the State Medicaid Plan but are covered under Specialized Consultative Services. These Activities take place with and without the person being present. These activities will be observed on at least a quarterly basis:

- Observing the individual prior to the development/revision of the Support Plan to assess and determine treatment needs and the effectiveness of current interventions/support techniques.
- Constructing a written Support Plan to clearly delineate the interventions and activities to be carried out by family members, caregivers, and program staff. The Support Plan details strategies, responsibilities, and expected outcomes.
- Training relevant persons to implement the specific interventions/supports/techniques delineated in the Support Plan and to observe the person, to record data, and to monitor implementation of therapeutic interventions/support strategies.
- Reviewing documentation and evaluating the activities conducted by the family members, caregivers, or program staff as delineated in the Support Plan with revision of that Plan as needed to assure continued relevance and progress toward achievement of outcomes.
- Training and technical assistance to family members, caregivers, and other individuals primarily responsible for carrying out the person's Plan of Care on the specific interventions/activities, delineated in the Support Plan, outcomes expected and review procedures.
- Participating in treatment team meetings.

Service Limitations:

- This service may not duplicate services provided to family members through Individual/ Caregiver Training and Education; and
- The total cost reimbursable under the waiver will not exceed $1500 per person per waiver year.

4.6.18 Specialized Equipment and Supplies

Specialized Equipment and Supplies include devices, controls, or appliances specified in the person's Plan of Care that enables the person to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. Items under this service shall be directly attributable to the person's ability to avoid being institutionalized and shall exclude those items which are not of direct benefit to the person. All items shall meet applicable standards of manufacture, design and installation.

Specialized Equipment and Supplies may not be purchased through the waiver specifically for use in the school setting.

The service includes the following categories of items:

Category 1: Adaptive Positioning Devices – standers, trays and attachments, prone boards and attachments, positioning chairs and sitters, multi-function physiosystem, bolster rolls and wedges, motor activity shapes, therapeutic balls, visualizer ball, physio- roll, therapy mats when used in conjunction with adaptive positioning devices.

Category 2: Mobility Aids – walkers, attachments, and accessories, swivel wheeled scoot-about, adaptive car seats for physically involved individuals, customized/specialized wheelchairs, strollers, accessories and parts for adults, repair of specialized/customized wheelchairs for adults, splints/orthotics for adults (including replacement materials and repairs), prosthetic/orthopedic shoes and devices for adults, protective helmets that are medically necessary for adults, specialized adaptive tricycles to improve the person's gross motor skills.

Category 3: Aids for Daily Living – adaptive eating utensils (cups/mugs; spoons, forks, knives, universal gripping aid for utensils, adjustable universal utensil cuff, utensil holder, non-skid inner lip plate, sloping, deep plates, scooper, plate guards, non-skid pads for plate/bowl, wheelchair cup holders); adaptive eating equipment; adaptive, assistive devices/aids including adaptive switches and attachments; mobile and/or adjustable tables and trays for chairs, wheelchairs, and beds; adaptive toothbrushes; universal holder accessories for dressing, grooming, and hygiene; toilet trainer with anterior and lateral supports; adaptive toileting chairs and bath chairs and accessories not on the State DME list: adaptive hygiene/dressing aids, adaptive clothing, non-disposable clothing protectors; reusable incontinence garments with disposable liners for individuals age two and above; dietary scales, food/fluid thickeners for dysphasia treatment; nutritional supplements that are taken by mouth such as those supplements covered by Medicaid for Home Infusion Therapy/Tube feedings; bed rails, assistive listening devices for individuals with hearing and vision loss (TDD, large visual display devices, Braille screen communicators FM systems, volume control large print telephones, teletouch systems); medication dispensing boxes.

4.6.19 Supported Employment

Note: It is important that the vocational/employment needs of individuals be included as a strong component of the person-centered planning process. Individuals who may be assessed as appropriate for a referral to Vocational Rehabilitation should be referred to that source. Once Vocational Rehabilitation has completed activities that fall under their purview, if the individual is in need of long-term supports and is currently on the waiver, Supported Employment is an appropriate service. Supported Employment through the waiver may also be provided to individuals who have already obtained employment and may need ongoing long-term supports. It is expected that Supported Employment will be provided under the waiver by the vendor that provided the assessment phase in order to insure consistency in service delivery, unless the individual and/or legally responsible person requests another provider.

Supported employment services consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting. This does not prohibit an individual in any way from being paid at or above minimum wage.

Supported employment is conducted in a variety of settings; particularly work sites in which persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training.

When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. **Documentation will be maintained in the file of each individual receiving this service that states:**

The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
2. Payments that are passed through to users of supported employment programs; or
3. Payments for vocational training that is not directly related to an individual's supported employment program.

Transportation will be provided between the individual's place of residence and the site of the supported employment, or between employment sites (in cases where the individual receives

supported employment services in more than one place) as a component of the services. The cost of this transportation is included in the rate paid to providers.

Service Limitation: Supported Employment must be reviewed every six months by the LME with continuing authorization contingent upon achievement of outcomes in the individual's Plan of Care.

Limitations: This service may not be provided at the same time of day that a person receives:

- Adult Day Health
- Day Supports
- Home and Community Supports
- Personal Care
- Residential Supports
- Respite Care
- Transportation

4.6.20 Transportation

Transportation is a service offered to enable individuals served through the waiver to gain access to waiver and other community services, activities and resources, specified by the Plan of Care. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's plan of care.

Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized.

Additional Medicaid payment will not be made to provider agencies to provide transportation to and/or from the person's residence and the site of a habilitation service when payment is included in the established rate paid to the provider.

Service Limitation: Transportation Services are limited to $1,200.00 per waiver year per person.

Limitations: This service may not be provided at the same time of day that a person receives:

- Adult Day Health
- Day Supports
- Home and Community Supports
- Individual and Caregiver Training
- Residential Supports
- Respite
- Personal Care
- Supported Employment

4.6.21 Vehicle Adaptations

Vehicle Adaptations are provided only if the cost effectiveness of vehicle adaptations, relative to alternative transportation services is established in the person-centered Plan of Care. Vehicle adaptations are devices, controls, or services that enable individuals to increase their independence and/or physical safety. The repair, maintenance, installation, and training in the care and use of these items are included. Vehicle adaptations, repairs, and maintenance of equipment shall be performed by the adaptive equipment manufacturer's authorized dealer according to manufacturer's installation instructions, and National Mobility Equipment Dealers' Association, Society of Automotive Engineers, and National Highway and Traffic Safety Administration guidelines. When appropriate, waiver recipients are referred to Vocational Rehabilitation Services to acquire vehicle adaptation consultation services.

The following types of adaptations to the vehicles are allowed:

- Door handle replacements.
- Door modifications.
- Installation of a raised roof or related alterations to existing raised roof systems to improve head clearance.
- Lifting devices.
- Devices for securing wheelchairs or scooters.
- Devices for transporting wheelchairs or scooters.
- Adapted steering, acceleration, signaling, and braking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel.
- Seating modifications.
- Safety/security modifications, including power-operated door openers.
- Handrails and grab bars.
- Installation of wheelchair flooring to insure wheelchair securement.
- Lowering of the floor of the vehicle.

Service Limitations:

- Alterations to vehicles are limited to vehicles owned by the individual, or the individual's family. Excluded are vehicles owned by staff of licensed facilities, licensed and non-licensed Alternative Family Living homes and foster homes, including guardians in those settings.
- The adaptations do not include the purchase price of the vehicle itself.

The cost of Vehicle Adaptations shall not exceed $15,000 over the duration of the waiver (three years). It is the responsibility of the case manager to track the cost of Vehicle Adaptations billed and paid for during a plan year, in order not to exceed the total amount of $15,000 over 3 years. Costs that were not paid during one waiver year must be added to the cost summary for the next waiver year.

- Recipients are referred to Division of Vocational Rehabilitation (VR) when appropriate. VR has staff with expertise in assessing the needs of the person and making specific

recommendations for the type of modification to meet the needs of the person with the vehicle. In the event that VR services are determined not to be an appropriate resource, the following process is utilized.

- All vehicles must be evaluated by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications. Both VR and dealers have staff to provide this type of assessment.
- All equipment purchased through CAP-MR/DD funds will utilize a bid or competitive invoice process to insure the most efficient use of Medicaid funds.

All Vehicle Adaptations must meet applicable standards and safety codes.

Note: Vehicle modifications do not cover the cost of the vehicle to be modified or the cost of rental of vehicles with adaptations on them. A family may choose to purchase a vehicle (new or used) that already has modifications on it. In such cases the process for approval of the adaptation remains the same. The price of the used lift on the used vehicle must be assessed and the current value may be approved. In such instances, the individual/family may not take possession of the lift prior to approval.

SECTION 5. CASE MANAGEMENT ROLES AND RESPONSIBILITIES

5.1 Responsibilities

Targeted case management is required for all individuals who participate in the waiver. Case managers provide a variety of functions critical to insure that services and supports address not only the health and safety needs of individuals receiving waiver funding, but also reflect the needs and preferences reflected in the person-centered Plan of Care. The individual/legally responsible person, the LME, the provider agencies and the case manager have a role in assuring that the proper services are delivered as planned to meet the person's needs. The case manager has overall responsibility for coordinating and monitoring the CAP-MR/DD services approved on the Plan of Care. In addition, the case manager coordinates the CAP-MR/DD services with other services, resources and supports available in the community, including supports provided by the person's family and friends. The case manager reviews/monitors all aspects of service delivery. The source of funding of a service does not affect the case manager's responsibilities regarding coordinating of, observing, monitoring and linking the person to services and supports.

The individual/legally responsible person assists the case manager, provider agencies and planning team in arranging and coordinating services. This includes informing the case manager of changes in situation and/or needs, cooperating in scheduling services and allowing required monitoring to occur. The person/responsible party should never sign or be asked to sign information that is blank or inaccurate. In addition, the case manager is responsible for obtaining new signatures from the individual/legally responsible party if the Plan of Care is revised after the original signatures were obtained, but before the plan is presented to the local approval unit.

More specifically, case management responsibilities include:

- Coordination and oversight of assessment and reassessment of the individual's level of care and need for services and supports. This includes coordination of any assessments needed by the individual as identified during diagnostic assessment.

- Facilitation and development of the person-centered Plan of Care.

- Submission of the initial Plan of Care, continued need reviews, and revisions to the Plan of Care to the LME service authorization unit or local approver**.**

- Initiation of services through completion of service order for authorized services. The case manager arranges the CAP-MR/DD services approved on the Plan of Care using a service order. Services are expected to be implemented within 45 days of Plan of Care approval. The case manager issues written orders for CAP-MR/DD services approved on the Plan of Care, or arranges for service orders if the services require orders from another individual. The order is sent to the provider agency with a copy of the entire Plan of Care before services are initiated. The LME maintains a copy. Provider agencies are notified in writing if a service order is discontinued. See the DMH/DD/SAS Services Records Manual for service order requirements.

- Service orders are not required for equipment/supplies billed through the LME/ Lead Agency.

- Support and assistance to individuals/legally responsible person during any grievance or appeals process, including provision of appeal rights.

- Locating and coordinating services and supports. Though the case manager does not control the provision of other services, the case manager must be aware of other services and supports being provided and how these services/supports are being provided. The case manager works with others involved with the person to help assure proper care and treatment, prevent duplication of services, and coordinate the services with the CAP-MR/DD services. The case manager reports any problems or concerns about a service to the responsible provider agency. The case manager also assists the person/legally responsible person in working with the service provider agencies. It is important that the case manager also coordinate and promote the use of natural supports in planning services and supports with the person/legally responsible person and the planning team.

- CAP-MR/DD is not intended to replace or duplicate other services and resources that are available to the person. The case manager assures that the person gets the best available treatment and care by carefully coordinating the CAP-MR/DD services with other services as well as the resources available in the community. For those persons with a broader array of needs than can be met with CAP-MR/DD, it is essential that the case manager fully utilize all resources to allow the individual to stay in the community. The case manager, with the person/legally responsible person and planning team, must look beyond just buying CAP-MR/DD services and explore what the community has to offer. This may include seeking assistance from community groups, private individuals, public agencies, and other entities.

- Monitoring of service delivery to assure quality of care as well as continued appropriateness of services.

The case manager is responsible for monitoring CAP-MR/DD services and all other services provided to the person as well as the overall care of the person. This activity also helps the case manager continually evaluate the person's need to participate and benefit in CAP-MR/DD**. The frequency of monitoring is specified in the Plan of Care but there must be no less than one face to face visit per month. Face to face visits must include periodic visits to the home of the recipient.**

The case manager reviews the provision of services as provided versus the ordering of those services and considers if those services are meeting their intended purpose. The case manager looks at the provider agency's performance and the person's response to the service, and then determines the need for adjustments in the service. Documentation of monitoring and the actions taken/planned as a result of the monitoring must be recorded in the person's record. The monitoring schedule must be sufficient to assure the health, safety and welfare of the person.

The case manager monitors for progress/lack of progress through observation, interview, and documentation review. The provider agency is required to make service documentation accessible to the case manager for review. The case manager should pay particular attention to the "by when" or target dates for outcomes/goals/objectives on the person's Plan of Care and update if billing is to continue beyond the projected target date. Billing may not occur for outcomes/goals/objectives that the person has attained unless there is justification for billing as a maintenance outcome/goal/objective.

The person/legally responsible person and their provider agency must allow the case manager to have face-to-face contact with the recipient every month and to monitor services per the Plan of Care. **If the person/legally responsible person refuses the contact and/or monitoring, services may be suspended.**

The lead agency may grant an exception to the required monthly face-to-face monitoring if a physician's statement indicates that the health or safety of the person would be at risk due to the case manager visit/monitoring. If an exception is granted to the required face-to-face visit, it is expected that the person's Plan of Care will address health and safety issues regarding contacts with other individuals in addition to the limitations regarding contact with the case manager. This includes community integration activities that are funded by CAP-MR/DD or other resources.

When monitoring reveals a change in the person's needs, situation or condition, the case manager, along with the person/legally responsible person and planning team, should consider changing the Plan of Care. Possible changes must be discussed with the person/responsible party and planning team. The team may also need to consult with other professionals. The case manager should also be alert to changes needed outside of Medicaid services. The case manager should assist the person/responsible party in considering and obtaining those changes.

Should an individual require a different level of care and need to be referred to another Community Alternatives Program (CAP/DA; CAP/C; or CAP-AIDS), the coordination of the transfer needs to made in conjunction with the other Community Alternatives Program. The same is true for individuals transferring to CAP-MR/DD from one of the other programs. Both the sending and receiving case managers need to keep each other informed of the status of the transfer and provide the terminating CAP sufficient notice of approval for termination from the original program. Remember that a person cannot receive services from two Community Alternatives Programs at the same time.

The case manager should be alerted to any change in the residency, for Medicaid purposes, of an individual. **If the individual's residency is expected to change to the Piedmont catchment area, the case manager should coordinate this change with Piedmont Behavioral Healthcare as far in advance of the move as possible.**

Note: absences, transfers and terminations are addressed in appendix H.

Coordination with DSS Medicaid Eligibility

The case manager is responsible for verifying a person's continuing eligibility for Medicaid. The case manager should send a written request to the person's Medicaid eligibility worker to be copied on form number DSS-8108, Titled "Notice of Benefits" and keep this form on file. Medicaid deductibles for the person are met monthly and should be coordinated by the case manager with the person/legally responsible person. The case manager and/or local lead agency must have a system in place to verify Medicaid eligibility monthly, including verifying that the person continues to be eligible for CAP-MR/DD. One of the ways this can be done is for the case manager to view the person's Medicaid card and observe that the appropriate CAP indicator code (CM) appears in the top left corner of the card.

SECTION 6. PROVIDER ROLES AND RESPONSIBILITIES

6.1 Responsibilities of an Enrolled Medicaid Provider Agency

The provider agency is responsible for meeting the terms of the provider participation agreement. The conditions of participation are included in the agreement. The provider agency must:

- Be qualified according to Medicaid laws and regulations in order to receive Medicaid payment for a service. This includes having and maintaining all required licenses, accreditation and/or DMH/DD/SAS approvals and enrolling with the Division of Medical Assistance (DMA) by entering into a Medicaid Provider Agreement.

- Accept only people for whom it can provide the ordered services.

- Bill Medicaid for all services provided using the provider's assigned Medicaid provider number. Provider agencies cannot choose to bill using the lead agency's provider number or through another enrolled provider agency's provider number.

- Assume responsibility for all services that it bills to Medicaid. The enrolled provider agency is responsible for the accuracy of the claims submitted for payment.

- Provide, supervise and monitor services according to Medicaid policies, procedures and applicable standards of practice.

- Use only appropriately trained personnel to furnish services and only licensed personnel when the specific task requires licensure.

- Keep records and documentation relating to the delivery of a Medicaid reimbursed service for five years from the date of the service. The provider agency must furnish any information that the U.S. Department of Health and Human Services and its agents, DMA and its agents, or the State Medicaid Fraud Control Unit requests regarding payments it received from providing Medicaid services.

- Ensure that information, including the person's Medicaid status, remains confidential, and give this information to only those who are authorized to receive it.

- Comply with the Social Security Act and Federal regulations concerning disclosure of ownership and control information and the disclosure of information about an agency's owners and other persons convicted of criminal offenses against Medicare, Medicaid, and the Title XX services program.

- Accept payment for Medicaid covered services in accordance with the rules and regulations for reimbursement, promulgated by the Secretary of Health and Human

Services and by the State of North Carolina, and established under the Medicaid Program. This includes accepting Medicaid payment as payment in full.

- Take all reasonable measures to ascertain the legal liabilities of third parties, including Medicare and private insurance, to pay for Medicaid covered services and, if third party liability is established, to bill the third party before billing Medicaid.

- Comply with Title VI of the Civil Rights Act of 1964 that states: "No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation under any program or activity receiving federal financial assistance."

- Comply with Section 504 of the Rehabilitation Act of 1973, as amended, that states: "No otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

- Comply with the Americans with Disabilities Act of 1990 which prohibits exclusion from participation in or denial of services because the agency's facilities are not accessible to individuals with a disability.

- Notify DMA of changes in:
    - Its qualifications to provide services;
    - The ownership of the agency;
    - The name of the agency;
    - The address of the agency; and
    - The agency's IRS number.

Note: If a provider agency fails to meet any of its Medicaid responsibilities, its Medicaid participation agreement may be revoked and/or Medicaid payments may be recouped.

6.2 Specific Provider Agency Responsibilities

The provider agency is expected to deliver quality care to the person and meet all of the other program requirements outlined in this manual. Providers of CAP-MR/DD funded services receive service orders from case managers for CAP-MR/DD waiver services once the Plan of Care has been approved and authorized based on the needs of individuals and the services approved on their Plans of Care. Case managers ensure that each provider of services has a copy of the individual's Plan of Care prior to implementation of the service, including outcomes to be achieved by provision of the service and a projected date of achievement. For CAP-MR/DD services, the provider agency is responsible for:

- Participating in person-centered planning for the development of the recipient's Plan of Care, including revisions, with the case manager and the person/legally responsible person.

- Recruiting appropriate personnel.
- Ensuring personnel are trained, and supervised in the provision of services.
- Ensuring back-up staff is available when the lack of immediate care would pose a serious threat to the recipient's health and welfare and formal providers are unavailable. If back-up staff is unavailable, the provider agency must document who provided services/support/care in the absence of the direct service employee.
- Implementing the services authorized on the service order.
- Developing training interventions/strategies for achievement of outcomes/objectives with the recipient and/or legally responsible person, and other planning team members, as appropriate, with copies provided to the case manager.
- Assisting in the coordination of services and communication with the recipient/family.
- Monitoring services authorized by service orders to ensure consistency with the Plan of Care.
- Reviewing and maintaining adequate documentation of services; making documentation available to LMEs/area programs and others as needed. The provider agency must also make available information requested by the lead agency about claims, including remittance advices or CMS-1500s, when there are questions about claims. Information must be available in the geographic catchment area that the person receives services.
- Notifying the case manager of significant changes in the individual's situation, needs and service delivery.
- Billing Medicaid for services as ordered and provided.
- Submitting incident reports to the LME.
- Reporting the need for protective services of a child due to suspected to suspected abuse, neglect, or exploitation according to General Statute 7B-301.
- Reporting the need for protective services of a disabled adult due to suspected abuse, neglect, or exploitation according to General Statute 108-A 102.
- Monitoring provision of services to ensure proper implementation of recipient services as determined by the Plan of Care and the service order. This includes supervision and training of staff providing direct services.
- Monitoring notes and billing to ensure integrity of all claims submitted to EDS for payment.
- Providing LMEs with copies of any licenses for all facilities in which services will be provided.
- Complying with all applicable rules and regulations of DMH/DD/SAS.

6.3 Changing Agency Ownership

The Medicaid participation agreement is not transferable. If a provider agency is sold or merged with another agency, the new entity must be enrolled if it wants to continue to be paid by Medicaid. The new agency must notify the DMA Provider Services Unit within 30 days of the

action if it wishes to continue as a Medicaid provider. If the notification is received after 30 days, there may be a break in the enrollment. A break in enrollment means that no Medicaid payments will be available between the date of the change in ownership and the effective date of the new enrollment.

6.4 Other Agency Changes

An enrolled provider agency notifies the DMA Provider Services in writing:

- Immediately if it no longer meets Medicaid provider enrollment requirements. This includes the failure of the agency to be qualified to provide the service for which it is enrolled.

  Caution: If an agency does not meet Medicaid requirements at the time a service is rendered, the service is not covered by Medicaid. If the agency is paid for such a service, the payment is subject to recoupment by DMA.

- Within 30 days if the agency changes its name, address, or IRS number for reasons other than a change in ownership.

6.5 Terminating Enrollment

If a provider agency no longer wishes to be enrolled, it notifies the DMA Provider Services Unit in writing. Either party may terminate the participation agreement without cause with written advance notification to the other party at least 30 days before the termination date. In addition, participation may be terminated as outlined in the agreement and in Medicaid policies.

Also, a provider agency must contact the case managers to coordinate the termination of any services that it is providing to CAP/MR/DD recipients.

SECTION 7. LEAD AGENCY RESPONSIBILITIES

7.1 Lead Agency Responsibilities

This section discusses the responsibilities of lead agencies that are usually the local area/county program/LME unless lead agency status has been reassigned.

Lead agencies have numerous responsibilities for the CAP-MR/DD waiver, as described below. Readiness criterion will be established and readiness to perform management functions related to CAP-MR/DD funded services delineated below are determined and monitored by the Division of MH/DD/SAS.

7.2 Basic Lead Agency Functions

General administrative functions that are the responsibility of the local lead agency include the following:

- Management of funding allocation process.
- Management of appeals for levels of care and services.
- Maintaining community relations: recipients/families, DSS, schools, Health Department, County Commission, advocacy groups, etc.
- Maintain service provider list, recruit providers to address unmet needs, provide training and technical assistance to provider agencies enrolled to provide services in the lead agency catchment area.
- Assure family/recipient awareness and choice for all available waiver services.
- Complete the endorsement process for providers seeking DMA enrollment.
- Submit requested information for DMA Quality Assurance reviews.
- Provide authorization of services.
- Investigate complaints regarding licensed and unlicensed MH/DD/SAS providers as required by DHHS rule.
- Oversee and monitor MH/DD/SAS services provided in the LME catchment area as required by DHHS rules inclusive of provider qualifications.
- Receive and review Critical Incident Reports from MH/DD/SAS providers as required by DHHS rules.
- Ensure that MH/DD/SAS providers complete death reports as required by DHHS rules.
- Ensure that reporting is made to the county Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that an individual may be abused, neglected or exploited and in need of protective services.
- For lead agency billed services, process billing, verify that billing does not exceed cost summary, transmit billing, post remittance advises, research denials and rebilling as indicated, and order/purchase non-service items (Augmentative Communication Equipment, Home Modifications, Specialized Equipment and Supplies, Transportation Services, and Vehicle Adaptations).

- Utilize paid claims as warranted by specific situations as needed with follow up on any discrepancies noted.
- Maintain an appropriate management information system (MIS).

LMEs must follow the provider endorsement process as outlined in Communication Bulletin #37 for endorsement of CAP-MR/DD providers.

APPENDIX A. REFERENCES

Division Manuals[9]

APSM 30-1 Rules for MH/DD/SAS Facilities and Services

APSM 45-1 Confidentiality Rules

APSM 95-2 Client Rights Rules in Community Mental Health, Developmental Disabilities and Substance Abuse Services

APSM 45-2 Service Records Manual for Providers of MH/DD/SA Services

APSM 10-3 Records Retention and Disposition Schedule for State and Area Facilities

[9] All manuals can be printed from the Division's web site at http://www.dhhs.state.nc.us/mhddsas/manuals/index.htm or purchased from the Division. Call the Division's Operations Services section at 919-715-2780 for cost and procedures.

APPENDIX B. GLOSSARY

The following definitions apply to the terms, abbreviations and acronyms used in this manual.

Access – where and how someone makes initial contact with the MH/DD/SAS system.

AFL- For the purposes of the CAP-MR/DD waiver, an Alternative Family Living Home or Adult Foster Home for one person is provided as an out of home placement for a person who chooses this setting or whose family cannot provide care for that person. The individual receives 24-hour care from and lives in a private home with a family in a home environment where the services are for the care and/or habilitation of the individual. The home does not require a license because it serves only one adult with a developmental disability. The LME and CAP-MR/DD case manager jointly monitor the health and safety of the person. CAP-MR/DD services may not be utilized as payment for room and board costs.

CAP effective date - The date that the individual's coverage for CAP services begins. It is the latest of three dates:

* the date of Medicaid application;
* the date of the MR-2 approval; or
* the date of de-institutionalization.

CAP-MR/DD - The acronym for the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities- provides home and community-based care as an alternative to care in an intermediate care facility for persons with Mental Retardation/Developmental Disabilities (ICF-MR).

CM Indicator – The initials in the CAP block on the Medicaid ID card that identifies the individual as a participant in the Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities.

CMS - The acronym for the Centers for Medicare and Medicaid Services, the federal agency that administers Medicare and Medicaid for the federal government.

Continued Needs Review Year- The 12 month period for the Continued Needs Review (CNR) Plan of Care year that runs from the first day of the month following the birth month to the last day of the month of the birth month.

Co-payment - The amount that a Medicaid recipient is responsible for paying for certain services, such as prescriptions and physician visits. CAP recipients do not pay co-payments.

County DSS - The county Department of Social Services: the local agency that determines Medicaid eligibility, eligibility for other assistance programs, and provides a variety of services in the county.

Deeming - A Medicaid eligibility term that refers to considering the income and/or resources of a Medicaid applicant's parent(s) or spouse as available to the applicant. The income or resources are "deemed" to be available to help meet the applicant's needs.

DFS - The acronym for the North Carolina Division of Facility Services located in the Department of Health and Human Services. This is the agency that licenses home care agencies, certifies home health agencies, and performs a variety of licensure, service monitoring, and health planning activities.

DHHS – The acronym for the North Carolina Department of Health and Human Services

Diagnostic Assessment – An intensive clinical and functional evaluation of a recipient's developmental disability that results in the issuance of a Diagnostic/Assessment report with a recommendation regarding whether the recipient meets target population criteria, and includes recommendations for service delivery that provides the basis for a person-centered plan.

DMA - The acronym for the North Carolina Division of Medical Assistance located in the Department of Health and Human Services. This is the agency that operates the Medicaid program for North Carolina.

DME - The acronym for durable medical equipment.

DMH/DD/SAS – The acronym for the Division of Mental Health/Developmental Disabilities/Substance Abuse Services. DMH/DD/SAS is the Lead Agency for statewide operations of this waiver.

DSS - An acronym used in two ways. Depending on the context, it may refer to the North Carolina Division of Social Services in the Department of Health and Human Services. This is the agency that administers public assistance programs (other than Medicaid) and service programs for children and adults. It may also refer to the county department of social services located in each county in the State.

EDS - The acronym for EDS (Electronic Data Systems) Corporation - the firm that handles claims processing

Enrollment -The term used for a provider becoming eligible for Medicaid payment. The provider enrolls with DMA to get a provider number that allows the provider to bill for Medicaid services.

HCBS - The acronym for home or community-based services. HCBS means services not otherwise furnished under the State's Medicaid Plan that are furnished under a waiver granted by CMS under Section 1915(c) of the Social Security Act.

Home Care Agency - An agency that is licensed by DFS to provide home care services and directly related medical supplies and appliances to an individual at his home. Home care services include nursing care; physical, occupational, or speech therapy; medical social services; "hands-on" in-home aide services; infusion nursing services; and assistance with pulmonary care, pulmonary rehabilitation, or ventilation.

ICF-MR - The acronym for Intermediate Care Facility for Persons with Mental Retardation; a licensed facility that provides care and treatment for individuals with mental retardation and certain developmental disabilities.

IDEA - The acronym for the Individuals with Disabilities Education Act.

IEP - The acronym for Individualized Education Program which is developed in a meeting that includes the child's parent(s), the child (when appropriate), one regular education teacher, one special education teacher, a representative of the local education agency, an individual who can interpret evaluation results, and others with special expertise about the child.

Initial Plan of Care Year - Describes the 12-month period used for planning services on the Initial Plan of Care. It begins the month of the CAP effective date and ends 12 months later. For example, if the CAP effective date is in November, the individual's Plan of Care year is November through the following October.

LEA – The acronym for the local education agency (i.e. school system).

LPN - The acronym for licensed practical nurse. In this manual it refers to a practical nurse licensed to practice in North Carolina.

IFSP - The acronym for Individualized Family Service Plan.

LME – The acronym for the Local Management Entity. LME is the local lead agency for the day to day operations of the waiver in the counties it serves. For the purpose of this waiver, LME also is inclusive of Area Authorities and County Programs.

Local Approval Process – The process by which Plans of Care are reviewed, resulting in a denial or approval, by the designated local approval staff at the local lead agency.

Medicaid Deductible ("Deductible") - The amount of medical expenses for which the individual is responsible before Medicaid will pay for a covered service.

Medicaid ID Card - The card issued monthly to identify individuals eligible for Medicaid coverage. The cards are blue, pink or buff. Each color denotes a certain type of coverage. See Chapter 5 for details.

MID - The acronym for Medicaid Identification Number; the individual identification number assigned to each Medicaid recipient. It consists of nine digits and an alpha suffix.

NCAC - The acronym for the North Carolina Administrative Code; the state regulations.

OT - The acronym for occupational therapy or occupational therapist, depending upon its use in the sentence. When used in this manual to designate an occupational therapist, it refers to one licensed to practice in North Carolina.

Person-Centered Planning – An approach in which the individual directs his/her own planning process with the focus being on the expressed preferences, needs and plans for his/her future.

Provider - The term used for the entity enrolled with Medicaid to provide a service.

Provider Participation Agreement - A legal agreement between the Division of Medical Assistance and a Medicaid provider stating that the provider understands and will follow Medicaid policies and procedures as well as applicable laws and regulations.

PT - The acronym for physical therapy or physical therapist, depending upon its use in the sentence. When used in this manual to designate a physical therapist, it refers to one licensed to practice in North Carolina.

Recipient - A person authorized for Medicaid coverage.

RN - The acronym for Registered Nurse. In this manual it refers to a registered nurse licensed to practice in North Carolina.

Screening and Triage – Screening involves a brief interview designed to first determine if there is a MH/DD/SA need and if the need is emergent, urgent, or routine. Secondly, screening will offer an initial determination as to whether or not the caller appears to be a member of a target population.

Social Security Income – Also referred to as SSI. It is direct, monthly cash payments to provide minimum income for individuals who meet a financial needs test and are elderly, blind, or have a disability.

Waiver - The home and community-based services waiver granted by the Centers for Medicare and Medicaid Services that allows North Carolina to operate the Community Alternatives Programs.

Waiver Year - The 12-month period that CMS uses to authorize, monitor, and control waiver programs and expenditures. The waiver year begins on the effective date of the waiver approval and includes the 12 months following that date. If a subsequent waiver renewal is approved with a different effective date, the waiver year changes to coincide with the renewal effective date.

Virtual Allocation – Allocation of funds provided by DMH/DD/SAS with the expectation that a minimum number of individuals be enrolled in the waiver each year.

NAME: _____ RECORD #: _____

APPENDIX C. PLAN OF CARE

_____'s Plan

Plan Meeting Date: _____

For Plan Approver Only
Plan Approved By: _____
Plan Approved Date: ___ / ___ / _____

Name (As appears on Medicaid Card)	**Preferred Name**
LME	**Case Manager**
Agency/Provider Name:	
Record Number	**Date of Birth**
Address	**Phone**
City, State, Zip	**Medicaid County**
Social Security Number	**Medicaid ID#:**
Gender: ☐ **Female** ☐ **Male**	**Medicare/Insuran**

Race/Ethnicity: White_ African Am__ Hispanic___
Native Am__ Asian__ Other___

TYPE
☐ Initial Plan
☐ CNR

CAP-MR/DD
☐ At Risk for ICF/MR Placement
☐ Previously in an ICF-MR bed

RESIDENCY
☐ Private home with natural family
☐ Individual Residence
☐ Supervised Living _____# of consumers
☐ Group Home _____# of consumers
☐ Child Foster Care
☐ AFL /Therapeutic Home
☐ **Other (Specify)** _____

☐ NC-SNAP Score _____

CONTACT PERSON

☐
Next of Kin/ Relationship

☐ **Legally Responsible Person**

Type:

Date of Action:

Name: _____

Address:

City/State/Zip

Phone (home):

Phone (work):

PARTICIPANTS IN PLAN DEVELOPMENT

NAME: _____ **RECORD #:** _____

Medical Information

Date Completed _____

	CODE	DIAGNOSIS	Indi
AXIS I			
AXIS II			
AXIS III			
AXIS IV			
AXIS V			

MEDICATION	TARGET SYMPTOMS of THIS PERSON (Inc. Frequency, Intensity, Specificity)

ASSESSMENTS (Including Medical and Dental)	LAST DATE	APPROX. DUE DATE

NAME: _____ **RECORD #:** _____

What has happened in life this past year (or if new plan, within the last few years)?
What goals have been met?

What does want his/her life to be like? What is important? What are his/her goals?

NAME: _____ **RECORD #:** _____

Who am I? What is important to me? What are my strengths and preferences?

What would I change about my life? What are problems or needs that I may have? What is not working in my life?

What will we accomplish with this plan?

NAME: _____ RECORD #: _____

What support do I need to maintain what is important to me in my life, and to change the things noted above in my life?

What natural supports are available to me? Family, friends, co-workers, etc.?

What community supports are available to me? Church, community organizations, civic groups?

In addition to the above, what other supports may I need including public funded supports?

Are there needs in my life related to health and safety, such as identified medical issues, need for behavior or crisis plan? If so, how will they be addressed?

What is the process for obtaining back-up staff in case of emergency?

NAME: _____ RECORD #: _____

Action Plan

This action plan is developed to help _____ meet his/her goals through addressing what needs to change and needs to be maintained as identified on the previous pages.

	DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #
METHOD OF EVALUATION:	

WHAT	HOW	WHO'S RESPONSIBLE	BY WHEN	SERVICE AND FREQUENCY

	DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #
METHOD OF EVALUATION:	

WHAT	HOW	WHO'S RESPONSIBLE	BY WHEN	SERVICE AND FREQUENCY

(Repeat page as necessary)

NAME: _____ **RECORD #:** _____

Case Management/Service Monitoring Plan

TYPE		FREQUENCY / CONTACT SCHEDULE
Face to Face:	Individual Family / Guardian Provider(s)	
Collaterals:	Individual Family / Guardian Provider(s) Education Others (residential/ vocational, etc.)	
	Service Observations / Visits Review of Service Documentation Review of Outcomes/Supports Strategies Review of CM Indicator on Medicaid Card	
Other / Comments		

Attached are the following documents (check all that apply):

NC-SNAP (required for new and renewal)	☐
Crisis Plan	☐
Behavior Plan	☐
Advanced Health/Mental Health Directive/DNR/PA	☐
Justification for Equipment or Supplies	☐
Individual Education Plan (IEP)	☐
Other (Explain)	☐

Signatures

The following signatures confirm the involvement of individuals in the development of this assessment and plan of care. All signatures indicate concurrence with the services/supports to be provided.

1) I confirm/concur my involvement in the development of this assessment and plan of care. My signatures indicate concurrence with the services/supports to be provided.

NAME: _____ **RECORD #:** _____

2) I understand that I have the choice of seeking care in an intermediate care facility for the mentally retarded instead of participating in the Community Alternatives Program for the Mentally Retarded / Developmentally Disabled (CAP/MR-DD). I choose to participate in CAP/MR-DD.
3) I understand that I have the choice of service providers and case managers and may change at anytime by contacting my case manager.

Individual: _____ Date: _____

Legally Responsible Person: _____ Date: _____

Case Manager:_____ Date:_____

_____ _____ Date:_____

_____ _____ Date:_____

_____ _____ Date:_____

NAME: ______________________ **RECORD #:** ____________

(1) Consumer Name: [ ] (2) Medicaid ID: [ ] (3) Consumer Record Number: [ ]

(4) Effective Date: [ ] (5) Revision Effective Date: [ ] (6) LME Name: [ ]

(7) SNAP Index Score: [ ]

CAP-MR/DD COST SUMMARY

(8) Service/ Equipment	(9) Service Code	(10) Provider Agency	(11) Units a Month	(12) Unit Interval	(13) FROM Date	(14) TO Date	(15) Established Rate	(16) Max. Monthly Authorization	(17) Annual CAP-MR Author.
(18) TOTAL MONTHLY AND ANNUAL AUTHORIZED CAP-MRDD WAIVER LIMITS									

Annual Authorization Limits Within LME Approval Authority

(19) Comments: [ ]

NAME: _____ **RECORD #:** _____

Plan Update/Revision

Implementation Date: _____

What has happened in _____'s life (personal or clinical) to cause the need for revision? *(Attach update NC-SNAP if there are changes)*

Based on what is happening in my life, what is important to me now? What are my strengths and preferences?

Based on what is happening in my life, what needs to change now? What new problems or needs do I have? What is not working in my life?

What do we need to know or do to support _____differently?

_____ **DESIRED PERSONAL, CLINICAL AND/OR FUNCTIONAL OUTCOME #**

_____

WHAT	HOW	WHO'S RESPONSIBLE	BY WHEN	SERVICE & FREQUENCY
			_____	_____

Required Signatures: The following confirms the involvement of the individual / guardian in the update of this plan including revision to the cost summary.

Individual: _____ **Date:** _____

Legally Responsible Person: _____ **Date:** _____

Case Manager _____ **Date:** _____

_____ **Date:** _____

APPENDIX D. WHO TO CONTACT

This appendix tells you the contacts for:

- Information about services, programs, claims issues, prior approval, and other related issues. This is information that goes beyond what is provided in this manual. Please review your manual before calling for information.
- Forms and other printed material.
- Determining claims status, Medicaid and MID numbers.
- Reporting possible fraud and program abuse, possible licensure violations and recipient insurance information.
- Addresses for sending various forms and to find other various information.

For information about:	**Contact:**
Automatic deposits	EDS Finance Unit 1-800-688-6696 or 919-851-8888
CAP/AIDS	AIDS Care Branch, DEHNR 919-715-3160
CAP/C	CAP Unit, DMA 919-855-4384,4383,4382
CAP/DA	CAP Unit, DMA 919-855-4360
CAP-MR/DD	Contact local LME
Care Line	1-800-662-7030
Carolina ACCESS	Carolina ACCESS representative at your county department of social services or Carolina ACCESS, DMA 1-888-245-0179 or 919-857-4022
DME Prior Approval	EDS Prior Approval Unit 1-800-688-6696 or 919-851-8888
Fraud and Program Abuse Reporting	Program Integrity, DMA 919-647-8000

Health Check	Call local department of social services
Health Choice	Call local department of social services
ICF-MR Level of Care	Murdoch Center, 919-575-1000
Independent Practitioner Program	Medical Policy, DMA, 919-855-4310
Medicaid Deductibles	Call local department of social services
Medicaid Eligibility Requirements	Call local department of social services

To Get:	**Contact:**
CAP-MR/DD Manual and other DMH/DD/SAS Manuals	Available on the web at: www.dhhs.state.nc.us/mhddsas/forms/index.htm
CAP-MR/DD Provider Certification Letter	Accountability Team, DMH/DD/SAS 3012 Mail Service Center Raleigh, NC 27699-3012 919- 881-2446
Community Care Manuals	EDS Provider Services Unit 1-800-688-6696 or 919-851-8888

To report:	**Contact:**
Fraud and Program Abuse	Program Integrity Section, DMA 2515 Mail Service Center Raleigh, NC 27699-2515 919-647-8000
Provider Compliance Issues	Accountability Team, DMH/DD/SAS 3012 Mail Service Center Raleigh, NC 27699-3012 919- 881-2446
Home Care/Home Health/Hospice Licensure Violations	Home Health Hotline, DFS 2712 Mail Service Center Raleigh, NC 27699-2712 1-800-624-3004 or 919-733-1601
Recipient Insurance Information	Call the local county department of social services
Piedmont Behavioral Health	704-721-7000

APPENDIX E. MEDICAID ELIGIBILITY AND CAP-MR/DD

Waiver of the Deeming of Income and Resources

When a member of a married couple, living together, applies for Medicaid, the spouse's income and resources count towards the applicant's eligibility. When a child living with his parents applies for Medicaid, the income and usually the resources of the parents are considered in determining the eligibility of the child. This is called the "deeming" of income and resources. When the spouse or child is in institutional care under specific conditions, deeming may not apply. Because CAP-MR/DD is an alternative to ICF-MR care, CMS has allowed North Carolina to waive the deeming requirement. The income and resources of a parent or spouse are not considered in determining the person' Medicaid eligibility.

The Medicaid staff will ask for the income and resources of a parent/spouse when the potential CAP-MR/DD recipient applies for Medicaid. The DSS is required to look at all ways that a person may be eligible for Medicaid. In some instances, this will be advantageous for the individual, as it will allow the individual to have regular Medicaid before the CAP-MR/DD Plan of Care is approved. Case Manger should inform parents and spouses that DSS may ask them about income and resources.

Medicaid Eligibility Referral

Case managers may assist individuals in the Medicaid eligibility process. The process followed by the case manager depends on whether or not the individual is a current Medicaid recipient.

- If the individual is not a Medicaid recipient the case manager refers the individual to the county DSS Medicaid staff. It may be necessary for the case manager to accompany the individual and his/her legal representative to the DSS office when the individual applies for Medicaid.
- If the individual receives Medicaid, the case manger notifies the Medicaid staff that the individual is being considered for CAP-MR/DD.

Appeal of Medicaid Eligibility

DSS takes applications and determines eligibility for Medicaid. If an individual/legally responsible person wants to appeal a decision about eligibility for MA, the case manager refers the individual/legally responsible person to the local DSS. The individual/legally responsible person has 60 days from the date of the notice of denial or termination to request an appeal. An impartial official of the county DSS will hear the appeal, make a decision, and notify the individual of the decision. If the individual disagrees with the decision and wants another hearing, he/she must contact the DSS and request a State hearing. A hearing officer from the NC Division of Social Services will conduct this hearing. A person who is not eligible for Medicaid is not eligible for CAP-MR/DD funding.

Deductibles

There are two provisions about deductibles that apply to an individual receiving CAP-MR/DD funding:

- The deductible for an individual receiving CAP-MR/DD funding is met monthly rather than on a six-month basis.
- In addition to the usual expenses allowed toward a deductible, an individual receiving CAP-MR/DD funding may use the cost of CAP-MR/DD services approved on the Plan of Care if they are provided during the deductible period.

Verifying Medicaid eligibility

The case manager is responsible for verifying an individual's continuing eligibility for Medicaid. The case manager should send a written request to the individual's Medicaid Eligibility worker to be copied on form number DSS-8108, Notice of Benefits. Medicaid deductibles for the individual are met monthly and should be coordinated by the case manger with the individual and legally responsible person.

Case mangers must be sure that the individual receiving CAP-MR/DD funding is authorized for Medicaid and eligible for CAP-MR/DD services. A new Medicaid card is issued each month. **The case management provider must have written procedure for verifying Medicaid eligibility and eligibility for CAP-MR/DD.** The case manager must check the card each month, being sure that a responsible person sees the card, or by checking the person's eligibility in the Medicaid Management Information System. This must be documented in the record. All CAP-MR/DD Medicaid recipients must have a blue or white Medicaid card with a **CM** indicator in the CAP block. The **CM** indicates that the system contains the information needed to process claims and allows the co-payment exemptions. Provider agencies will not be paid for CAP-MR/DD services unless the eligibility system shows the individual is receiving CAP-MR/DD funding.

Coordinating with the local Department of Social Services (DSS)

Activities must be coordinated with the DSS Medicaid staff to insure that the individual receives CAP-MR/DD benefits, as well as to insure that provider agencies are reimbursed for service delivery. Case managers should establish a DSS contact person for each CAP-MR/DD recipient. Key areas requiring communication and coordination include:

- Referring a potential CAP-MR/DD funding recipient to DSS is critical to initiating a Medicaid application.
- Promptly processing the Plan of Care to get an approval from the LME as important both for the individual as well as DSS. DSS has strict time limits to act on applications. If the Plan is not approved within the time limit, DSS may deny the Medicaid application.
- Coordinating deductibles helps recipients as well as provider agencies. The case manager should work with DSS Medicaid staff and the individual or responsible person to be sure that there is clear understanding of what may be used to meet the deductible, what proof is required for expenses, and who will provide the proof to DSS. If the individual has a deductible, a copy of the current Cost Summary should be provided to DSS.

- Notifying DSS about CAP-MR/DD changes is necessary to be sure that the individual receives the proper benefits and is given the proper notices about changes in Medicaid eligibility.
- Termination from CAP-MR/DD services must be coordinated with DSS in order to meet advance notice requirements.
- If the individual is hospitalized, placed in an ICF-MR facility, admitted to a state psychiatric facility, or will be absent for 30 days or more, DSS must be notified.

APPENDIX F. APPEALS

This section describes CAP-MR/DD denials, reductions, and termination procedures and outlines the appeal process for CAP-MR/DD decisions. Also, this Section offers general information on the appeal of Medicaid eligibility. DMH/DD/SAS offers technical assistance on processing appeals through the Customer Services and Community Rights Team. Regardless of the type of appeal, the case manager offers support and assistance to the person/legally responsible person during the appeals process. Information regarding all Medicaid rights and appeals processes may be found at the Division of MH/DD/SAS website at www.dhhs.state.nc.us/mhddsas/consumeradvocacy/index.htm

Appealing Medicaid Eligibility

DSS takes applications and determines eligibility for Medicaid. If a person/legally responsible person wants to appeal a decision about eligibility for Medicaid, the case manager refers the individual/legally responsible person to the local DSS. A person may appeal decisions regarding initial or continued Medicaid eligibility. He/she has 60 days from the date of the notice of denial or termination to request an appeal. An impartial official of the county DSS will hear the appeal, make a decision, and notify the individual of the decision. If the individual disagrees with the decision and wants another hearing, he/she must contact the DSS and request a State hearing. A hearing officer from the NC Division of Social Services will conduct this hearing. A person who is not eligible for Medicaid is not eligible for CAP-MR/DD funding.

Appealing Disability Determination Decisions

If a person does not have Medicaid at the time he/she applies for CAP-MR/DD funding, the person may be referred by the local DSS to the State Office for Disability Determination for a decision regarding disability determination. Should this office decide that the person does not meet criteria, the person/legally responsible person will be notified and given the opportunity to appeal as well as timelines/process for the appeal. A person who does meet the criteria established for disability determination is not eligible for CAP-MR/DD Medicaid.

Appealing Level of Care Decisions

Information regarding appeals of Level of Care may be found in Section 2.6 of this Manual.

Appealing Physicians Recommendations

Recommendations by the person's physician are not appealable. These include:

- A physician's recommendation for the level or type of care. The physician's recommendation is not appealable to Medicaid.

- A physician's order for services. Medicaid only pays for the services as recommended by a physician. If the person's physician recommends termination or denial of a service, the physician's recommendation is not appealable.

  Example: An individual who is participating in CAP-MR/DD feels he/she would benefit from physical therapy and requests that this service becomes part of the Plan of Care. The person's physician states physical therapy is not recommended and refuses to order the service. If a physical therapist orders therapy and the physician disagrees, PT may not be billed to Medicaid.

Appealing Prioritization Decisions

If a person or his/her legal representative desires to appeal a Lead Agency prioritization decision, the DMH/DD/SAS Appeals process is followed. This may be found at www.dhhs.state.nc.us/mhddsas/consumeradvocacy/index.htm

Appealing Provider Terminations

Terminations or denial of services to a CAP-MR/DD recipient by a provider agency other than the Lead Agency are not appealable. Providers of CAP-MR/DD services or other Medicaid services may refuse to serve a CAP-MR/DD recipient. The provider agency's decision not to serve a client cannot be appealed. The provider agency must notify the person/legally responsible person in writing of the decision to terminate and must give the person two weeks notice from the date of receipt of the letter of termination before the effective date of the termination. A provider agency may be exempt from the two weeks notice requirement if a health or safety issue is the reason for the termination. The person's case manager notified DMH/DD/SAS

CAP-MR/DD Denials, Reductions, Suspensions, and Terminations

Denials, reductions, suspensions, and terminations of CAP-MR/DD participation result from issues involving cost-effectiveness or health, safety, and welfare. If an individual does not have CAP-MR/DD and requests a hearing, rule out level of care and Medicaid eligibility issues to make sure a DMH/DD/SAS hearing is appropriate.

A denial of CAP-MR/DD is the refusal to initiate CAP-MR/DD services to an individual who:

- Is approved for ICF-MR level of care;
- Is eligible for the appropriate category of Medicaid; and
- Has been assessed for CAP-MR/DD and found eligible.

Note: An individual who does not meet all of the criteria listed above does not have the right to appeal the denial of CAP-MR/DD services or receipt of a waiver funding.

A termination of CAP-MR/DD participation is discontinuing the authorization of all CAP-MR/DD services to an individual who:

- Continues to meet ICF-MR Level of Care
- Continues to be eligible for Medicaid under CAP-MR/DD, and;
- Has been participating in CAP-MR/DD

A reduction of CAP-MR/DD supports is the lowering of the amount or type of supports being provided to an individual who:

- Who continues to be approved for CAP-MR/DD services;
- Continues to meet the monthly allowable expenditure

Lead Agencies that make a decision to deny, reduce or terminate CAP-MR/DD services follow the DMH/DD/SAS Medicaid Appeals process.

CAP-MR/DD Denials and Terminations by Lead Agency or Service Authorization Unit

This section is for the applicant or recipient who is dissatisfied with a decision made by the Lead Agency local approver or Service Authorization Unit when services are terminated or denied by the local approver. An appeal of a decision by the local approver should follow the DMH/DD/SAS appeals process.

APPENDIX G. CAP-MR/DD WAIVER CODES

CODE	DESCRIPTION	FEE/UNIT
S5102	Adult Day Health, per diem	$36.51/day
T2028	Augmentative Communication Devices - Purchase	As needed
V5336	Augmentative Communication Devices – Repairs and Service	As needed
H2011	Crisis Services	$6.04/15 minutes
T2021	Day Support – Individual	$5.94/15 minutes
T2021HQ	Day Support – Group	$3.31/15 minutes
T1019	Enhanced Personal Care	$5.00/15 minutes
T1005	Enhanced Respite Care	$5.00/15 minutes
H2015	Home and Community Supports – Individual	$5.65/15 minutes
H2015HQ	Home and Community Supports – Group 2 or more clients	$3.15/15 minutes
S5165	Home Modifications	$15,000.00 limit over 3 year waiver
S5110	Individual/Caregiver Training and Education	$9.00/15 minutes
S5161	Personal Emergency Response System (PERS)	$29.67/month
T2025	Specialized Consultative Service	$18.75/15 minutes
S5125	Personal Care Services	$3.60/15 minutes
S5150HQ	Respite – Non Institutional Group (2-3 clients)	$2.78/15 minutes
S5150	Respite – Non Institutional Individual	$3.60/15 minutes
T2027	Day Supports – Specialized Childcare	$6.04/15 minutes
H0045	Respite Care – Institutional	$222.96/day
T1005TE	Respite Care – Nursing Level LPN	$9.11/15 minutes
T1005TD	Respite Care – Nursing Level RN	$9.11/15 minutes
T1999	Specialized Equipment and Supplies	As needed
H2025	Supported Employment – Individual	$7.61/15 minutes
H2025HQ	Supported Employment – Individual	$1.97/15 minutes
H2016	Residential Supports Level I	$102.33/Day
T2014	Residential Supports Level 2	$125.45/Day
T2020	Residential Supports Level 3	$145.17/Day
H2016HI	Residential Supports Level 4	$175.35
T2001	Transportation	$1,200.00/year
T2039	Vehicle Adaptations	$15,000.00/duration of waiver (3 years)

APPENDIX H. ABSENCES, TRANSFERS AND TERMINATIONS

Absences

The action needed depends on the nature of the absence.

Hospitalizations

When a person is admitted to a hospital, the Case Manager suspends the delivery of CAP-MR/DD funding. No CAP-MR/DD services may be billed to Medicaid for a person who is hospitalized. The Case Manager notifies the service Provider Agencies of the suspension and the projected resumption date. The length of time the person is hospitalized determines what else must be done.

- **If 30 days or less**, there usually are no special actions required beyond the normal tasks of coordinating the temporary changes in services with Provider Agencies, monitoring the person's situation, and working with hospital discharge planners and others to assure services and supports upon discharge. The Case Manager notifies the DSS Medicaid staff of the admission. Supplies and equipment on the person's Plan of Care cannot be provided or billed to Medicaid during hospitalizations.

- **If over 30 days**, the Medicaid staff must cease CAP-MR/DD funding and close the CAP-MR/DD indicator on the Eligibility Information System (EIS). This removes the person from CAP-MR/DD funding. The Case Manager contacts the Medicaid staff to learn the effective date. Once the Medicaid staff determines the effective date of the termination, the Case Manager follows the termination procedures. If the person later wishes to be re-enrolled to CAP-MR/DD, the Case Manager considers the person a new participant.

- **Admission to ICF-MR or Other Institution:** When a CAP-MR/DD funding recipient is admitted to an ICF-MR facility, nursing facility, or psychiatric institutional setting other than a hospital, the person must be terminated from CAP-MR/DD on the date of institutionalization. If the person wishes to resume CAP-MR/DD participation upon discharge, the Case Manager considers the person a new participant.

Temporary Absence from Area

When a person temporarily leaves the area, the Case Manager suspends the delivery of CAP-MR/DD services. The Case Manager tracks the length of the absence as extended absences can affect Medicaid eligibility. If the absence is 30 days or more, the Case Manager notifies the Medicaid staff. The Case Manager contacts the Medicaid staff to learn the effective date of CAP-MR/DD termination. Once the Medicaid staff determines the effective date of the termination, the Case Manager follows the termination procedures.

Service Breaks

The person may miss a service for a variety of reasons. Holidays, family vacations, weather conditions, illnesses, and scheduling conflicts can cause brief interruptions in services. Breaks in service for greater than a few days need to be documented by either the Case Manager or direct service employee. When such an interruption occurs, the Case Manager may arrange for the service to be rescheduled.

Transfers

A person may be transferred to another Lead Agency. Usually this happens when the person moves to another county that is served by a different Lead Agency. While people usually participate in CAP-MR/DD funding in the Lead Agency of their home county, i.e., through the county as determined by Medicaid staff, there may be reasons that another Lead Agency is the agency of participation. In all situations the person's Lead Agency Home County is the Lead Agency where the person/legally responsible person enters.

If consideration is given to transferring the person from one Lead Agency to another, the person must be referred to the Lead Agency where he/she is transferring. Once a decision is reached regarding transfer of a the person to a new Lead Agency, the sending Lead Agency initiates completion of written notification and sends it to the receiving Lead Agency. The two Lead Agencies should take care in establishing the transfer date to insure continuity of care. LMEs/area programs are expected to accept individuals who move to their catchment area and become legal residents of the catchment area, with the exception of movement to or from Piedmont Behavioral Healthcare Catchment Area.

Movement from CAP-MR/DD to Piedmont Behavioral Healthcare Catchment area (Medicaid originates from Cabarrus, Davidson, Rowan, Stanly, Union counties): When a person participating in the CAP-MR/DD waiver becomes a legal resident (for the purposes of Medicaid eligibility) of the Piedmont catchment area, the individual is no longer eligible for CAP-MR/DD and is referred to the Piedmont 1915 C home and Community Based waiver, Innovations, by completing the Piedmont Innovations Referral Form. The sending LME provides the Piedmont Access/Utilization Management Department with the referral form and all requested information. Entrance into the Innovations waiver depends on funding and slot availability. The sending LME should contact Piedmont as soon as the person indicates that they are moving to the Piedmont catchment area to obtain the referral form. Because Piedmont operates under a captivated waiver, the effective date of the termination from the CAP-MR/DD waiver will be the last day of the month following the person's established residency in the Piedmont catchment area. A person's funding/slot does not transfer from the CAP-MR/DD waiver to the Piedmont catchment area. A person may not remain on the CAP-MR/DD waiver if residency changes to the Piedmont catchment area. Other exceptions to this should be because of extenuating circumstances and should be worked out between the LMEs/area programs. If the person/legally responsible person disagrees with the transfer, then the Grievance Procedure of the person's current Lead Agency is followed.

If the person's Medicaid County is changing because of a move to a new address, the Case Manager must work with the Department of Social Services to ensure continued Medicaid eligibility. The sending LME must also make certain that the receiving LME/area program has all necessary information regarding a person's receipt of CAP-MR/DD funding prior to the date of transfer.

Funding that the person is utilizing belongs to that person and transfers to the receiving Lead Agency. If the person leaves the funding, it remains with the receiving LME.

Terminations

This section provides guidance on terminating a person from CAP-MR/DD. The termination may be due to a variety of reasons, including ineligibility for Medicaid, institutionalization, or failure to qualify for program participation. Depending on the reason for termination, it may be initiated by the county Department of Social Services, Lead Agency Service Authorization unit or local approver, the Lead Agency, or the person/legally responsible person.

The following material covers the usual types of terminations. Keep the following in mind:

- Terminations must be completed with full regard for the person's rights, including those related to a fair hearing.
- For most terminations, the effective date is the last date of the month. The exceptions are noted in this Section.

- All terminations **must** be coordinated with DSS.

Written notifications of terminations must be sent to the person/legally responsible person, DSS, the DMH/DD/SAS waiver Office, and DMA.

DSS Terminates Medicaid Eligibility

If DSS proposes to terminate the person's Medicaid eligibility, it will send a notice to the person/responsible party. Medicaid rules determine the timing of the notice. In many instances, it is sent at least 10 days prior to the proposed date of action. The notice states the proposed termination date, the reason for termination, and appeal rights. Medicaid terminations usually are effective the last day of the month. In some instances, the person's eligibility for Medicaid will continue through the appeal process. The person may continue CAP-MR/DD services as long as the person remains eligible for Medicaid and CAP-MR/DD.

Lead Agency Disapproves Plan of Care

If the Lead Agency Service Authorization Unit or local approver does not approve a person's Plan of Care, it notifies the Case Manager in writing to begin the termination process and reminds the Case Manager to coordinate actions with DSS. The LME Service Authorization

Unit/local approver sends a copy of the letter to the Medicaid supervisor in the county DSS. The Case Manager notifies DSS and the person /legally responsible party in writing of the termination and the right to appeal the decision. Also, the Case Manager sends written notices to the Provider Agencies to stop services.

- If the person /legally responsible person accepts the decision, the Case Manager notifies DSS that he/she is proceeding with the termination.

- If the person /legally responsible person wishes to appeal the decision, the Case Manager provides the appeal rights. The Case Manager keeps DSS and Provider Agencies informed of the status of the proposed termination.

Recipient Institutionalized

If the person is admitted to an ICF-MR or nursing facility, the Case Manager terminates the person on the date of admission. Also, if the person is admitted to a hospital for a stay longer than 30 days, the Case Manager terminates the person from CAP-MR/DD. The Case Manager does the following:

- Sends written notification of the termination to DSS;

- Informs the person /legally responsible party in writing of the termination;

- Sends written notification to Provider Agencies to stop services; and

Recipient Moves Out of Area

If the termination of CAP-MR/DD is due to the person moving out of the state, the termination date is the date of the move. The Case Manager notifies Provider Agencies in writing to stop services. The Case Manager also notifies DSS of the termination. Notification of termination must be written.

Recipient Dies

If the person dies, the Case Manager notifies DSS, Provider Agencies, and DMH/DD/SAS of the death. Medicaid will not pay for any services after the date of death. Notification of termination must be written.

Other CAP-MR/DD Terminations

If the termination is for reasons other than those covered above, the Case Manager coordinates the proposed termination date with DSS. The Case Manager must give the person at least 10 days written advance notice of the proposed termination. The reason for termination and the person's appeal rights must be included. The date of termination is the last day of the month of CAP eligibility. The LME must be notified of any terminations.

APPENDIX I. DOCUMENTATION AND RECORDS

A Provider Agency must document the provision of a service before seeking Medicaid payment. Effective September 1, 2003, CAP-MR/DD Services shall be documented in accordance with the Service Records Manual for Providers of MH/DD/SAS Services. Lead Agencies and Provider Agencies must also keep related personnel, financial and other management records as required by the Medicaid Provider Participation Agreement, the policies and procedures in this manual, Medicaid rules, and State and Federal law.

Remember: This section includes CAP-MR/DD minimum requirements for recipient records and related information. Nothing in this section relieves a Lead Agency or other Provider Agencies from the DMH/DD/SAS requirements, licensing rules, and other applicable requirements.

How Long Records Must Be Kept

The records must be maintained by the Provider Agency for five years from the date of service.

Availability of Records

The provider agency must furnish information regarding its Medicaid payments that is requested by DMA and its agents, DMH/DD/SAS (including the local lead agencies), the Office of the Attorney General, the Department of Health and Human Services, the Centers for Medicare and Medicaid Services, and any other entities specified in the Medicaid Provider Participation Agreement.

In addition, the Provider Agency must allow the CAP-MR/DD case manager, lead agency staff, DMH/DD/SAS, DMA, and/or CMS to review the documentation that supports a claim for CAP-MR/DD services rendered and billed. Provider agencies must bring/mail documents to designated sites during state and/or federal reviews.

APPENDIX J. QUALITY MANAGEMENT PLAN

The North Carolina public system for mental health, developmental disabilities, and substance abuse services is in the fourth year of a seven-year comprehensive restructuring and reform process that builds on reform legislation passed in 2001. Key components of this reform include:

- Consumer involvement at all levels,
- An emphasis on home and community based services, including CAP-MR/DD waiver design and development to:
  - Address the needs of individuals at the ICF-MR level of care in the community;
  - Provide services and supports that will enable individuals to move from ICF-MR state operated facilities and group homes into the community;
  - Better tailor services to individuals through a person centered approach to planning;
  - Offer service options that will facilitate individuals continuing to live in or return to live in private residences.
- Local accountability,
- Effective services and supports based on evidence-based practices,
- Data-driven and outcomes-focused decision making.

Design of the Quality Management System

Development of a Quality Management (QM) system for the CAP-MR/DD waiver and the system as a whole is one of the fundamental building blocks of Mental Health/Developmental Disabilities/Substance Abuse Services reform in North Carolina. It is the intent of the State MH/DD/SAS Plan that a QM system integrates and analyzes information from multiple sources and functions within the state service system. Quality Management processes must be accountable to all stakeholders and findings must be published, including the assessment of quality improvement activities. The specific objectives related to QM are:

- The Division will develop and execute a comprehensive QM system focusing on continuous quality improvement.
- The QM system will be outcome-based.
- Performance indicators for all levels of the system will be included in the QM process.
- The Division will develop measurement criteria for models of best practice to be included in the QM system.

- The Division will establish competency requirements for all segments of the mental health, developmental disabilities and substance abuse services workforce.

- The Division will manage a comprehensive training and education strategy to support the new QM system.

The redesigned QM system including the CAP-MR/DD waiver will incorporate the Home and Community-Based Services (HCBS) Quality Framework. The QM Team has identified measures within each of the framework's domains that correspond to the goals of the State Plan and the CAP-MR/DD waiver.

Note that an early product of the work described here will be a State Quality Management Work Plan, detailing how DHHS will meet the QM requirements in the HCBS Draft Waiver application over the course of the 3-year period covered by this application. A key component of the efforts to create a comprehensive QM system is a Real Choice Systems Change Grant for QA/QI in HCBS awarded by CMS in 2003.

While the foundation of the QM system is already in place, the NC MH/DD/SAS is using this grant to complete the development and implementation of the information feedback loops that are critical to a system based on continuous quality improvement. The data and performance measures referenced above will be rolled into a cohesive process where information is used to assure quality and drive system improvement. Toward that end, work under the Systems Change Grant will accomplish the following goals:

- Evaluate the process and outcomes of transitioning consumers from institutional to home and community–based care through data collected in face-to-face interviews with transitioning consumers, using other consumers and family members as interviewers;
- Develop a comprehensive, coordinated system of Quality Improvement (QI) committees among provider agencies, local management entities and the NC Department of Health and Human Services (DHHS);
- Use the transition interview data and QI committees to pilot ways to improve service delivery and consumer outcomes and satisfaction through QI processes;
- Develop a long-term plan for expanding the focus of the QI committees to encompass other populations, services, and processes.

This document describes QA/QI processes that are currently taking place and future QA/QI processes in development are being planned as part of the CMS grant activities. The next section provides an overview of the organizational structure of the system and the responsibilities and activities of the primary entities involved in QM. The section also describes the specific quality assurance activities at the local and State level in regard to the CAP-MR/DD waiver. The remainder of the document is organized around the HCBS Quality Framework domains and the CMS regional review protocol components.

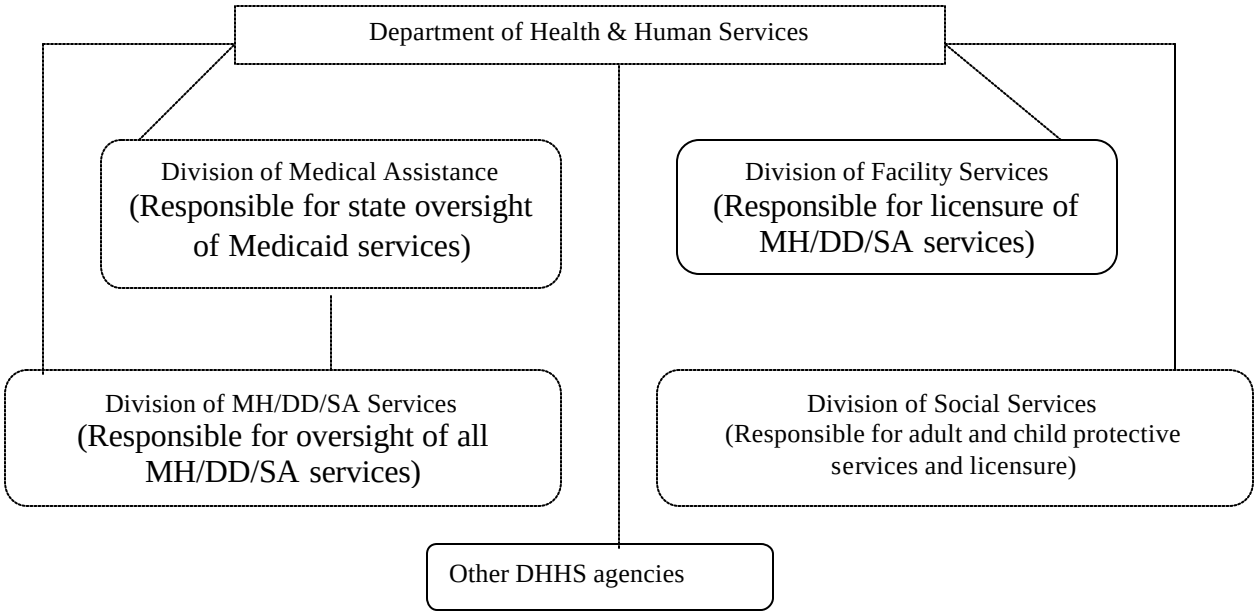
Organizational Context for Quality Management

A quality management system is built around a coordinated approach that defines, assigns, and interprets quality related activities across various cooperative entities. The following section describes those entities and their respective roles in the North Carolina system.

State Authority for the Waiver

According to federal and state guidelines, the NC Division of Medical Assistance (DMA) has responsibility for the overall operation of the HCBS waiver. The North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) is the lead agency for overseeing the daily operations of this waiver. The two Divisions cooperate in the operation of the waiver program under a memorandum of understanding that delineates each Division's responsibilities. The Division of Facility Services (DFS), the Division of Social Services (DSS) and the Division of Aging and Adult Services (DOA) have legally mandated responsibilities for licensure of facilities (DFS) and for child (DSS) and adult protective services (DOA.). All of these Divisions are under the authority of the Department of Health and Human Services (DHHS). These relationships are depicted on the chart in Figure 1 below.

Figure 1: NC Department of Health and Human Services



Quality Assurance Responsibilities and Activities within the MH/DD/SAS System

Quality assurance and improvement responsibilities are shared across multiple entities. The system relies on each entity to fill a distinct role while interacting with the other entities. The North Carolina QM system starts with consumers and their families, and builds in a coordinated way to the highest levels of state oversight.

Consumers/Families

Consumers and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). The CFACs:

- Comment on state and local plans and budgets,
- Help identify under-served populations and gaps in the service array,
- Participate in the monitoring of service development and delivery,
- Advise on the development of additional services and new models of service delivery,
- Participate in quality improvement projects at the provider and LME level.

Local CFACs also participate in a "mystery shopper" evaluation of provider performance and response to service requests.

Providers

Provider agencies are responsible for:

- Licensure and certification,
- Providing Targeted Case Management,
- Development of person-centered plan of care,
- Development of internal quality improvement plans,
- Maintaining internal client rights committees.

Local Management Entities (LME)

The Local Management Entities (LME) are the local lead agencies for the counties they serve, and are responsible for the administration and operation of MR/DD waiver programs in their areas. The functions of the LME include:

- Local business planning to ensure congruence with the State Plan;
- Governance, management and administration;
- Development of a community of qualified providers;
- Operation of a uniform local access system;
- Evaluation and continuous quality improvement;
- Financial management and accountability;
- Management of secure information systems with data on consumers, providers services and finances;

- Service monitoring and oversight, including provider compliance with standards, utilization and performance reviews;

- Technical assistance to providers.

LMEs enter into an annual Performance Contract with DHHS that define the responsibilities of the LME as a waiver lead agency and describe performance standards the LMEs are expected to meet.

North Carolina Department of Health and Human Services

Figure 1 (above) illustrates the divisions within the Department of Health and Human Services (DHHS) involved in implementing the HCBS waiver, and describes each of their responsibilities.

- DMA delegates approval authority for the waivers to DMH/DD/SAS and the Local Management Entities (LMEs).
- DMH/DD/SAS has primary responsibility for implementing the QM procedures for the waivers at the state level. These responsibilities include:

    - Ensuring compliance with all state and federal audit requirements;
    - Collecting and managing all program and consumer data;
    - Researching and developing evidence based best practice models;
    - Supporting consumer involvement at all levels of the system;
    - Providing training and technical assistance to LMEs

- DMH/DD/SAS and DMA together are responsible for:
    - Oversight of contracts with Local Management Entities (LMEs);
    - Setting performance standards for LMEs;
    - Monitoring regulatory compliance with state, federal, and waiver requirements

CAP-MR/DD Waiver Quality Assurance Activities and Frequency of Activities

Quality Assurance activities begin at the local level with the individual, Consumer and Family Advisory committees, providers, case manager, and the LME. At the state level, activities are completed by the DMH/DD/SAS and DMA in the Department of Health and Human Services (DHHS).

Individuals will:

- Contact their case managers if they have concerns about their services or supports
- Access grievance and complaint processes, with assistance from their case managers, if needed, based on written materials provided by the LME

Individuals and their families are represented at both the state and local level through Consumer and Family Advisory Committees (CFACs). The CFACs:

- Comment on state and local plans and budgets,
- Help identify under-served populations and gaps in the service array,
- Participate in the monitoring of service development and delivery,
- Advise on the development of additional services and new models of service delivery,
- Participate in quality improvement projects at the provider and LME level.

Provider Agencies will:

- Ensure that staff are qualified to deliver services and receive required supervision
- Monitor the provision of services
- Complete Incident Reports as required by DHHS rules
- Complete Death Reports as required by DHHS rules
- Contact the case manager if there are any concerns about the health or safety of the individual receiving services

The Case Manager will:

- Make a minimum of a monthly face-to-face visit with the individual to inquire about any concern or problem with service provision.
- Reassess each individual's needs at least annually and develop a revised person centered Plan of Care based on that reassessment.
- Follow-up and resolve any issues related to the individual's health, safety, or service delivery. Unresolved issues will be brought to the attention of the LME.

Local Management Entities will:

- Provide information to waiver participants about their rights, protections and responsibilities, including the right to change providers. Individuals will also be notified of grievance and complaint resolution processes.
- Resolve issues related to any individual's health, safety or service delivery that are unresolved by the case manager.
- Investigate complaints regarding licensed and unlicensed MH/DD/SAS providers as required by DHHS rules
- Oversee and monitor MH/DD/SAS services provided in the LME catchment area as required by DHHS rules inclusive of provider qualifications
- Receive and review Critical Incident Reports from MH/DD/SAS providers as required by DHHS rules
- Ensure that MH/DD/SAS providers complete death reports as required by DHHS Rules
- Ensure that reporting is made to the County Department of Social Services if the circumstances surrounding an incident, complaint or local monitoring reveal that an individual may be abused, neglected or exploited and in need of protective services
- Complete and submit Quarterly Reports to DMH/DD/SAS, and the local Client Rights Committee to include the following:
- Incidents
- Complaints concerning the provision of public services
- •Complete and submit a report of monthly local monitoring activities to the Division of Facility Services and DMH/DD/SAS that identifies provider monitoring issues requiring correction and an explanation of uncorrected issues.
- Provide on-call emergency back-up through the LME to provide staff in the event that the emergency back-up strategies identified in the person centered Plan of Care cannot be implemented and there is potential that the person's health and welfare would be jeopardized.

The DHHS will complete:

- Monitoring of CAP-MR/DD providers. Monitoring includes yearly audits of paid claims to CAP-MR/DD providers. The sample used in determining the providers to be audited is chosen so as to offer statistical assurance of the overall performance of all CAP-MR/DD providers. In addition, providers with previous records of low performance are routinely included in the sample. The State undertakes reviews of local approval protocols for Plans of Care to assure inter-rater reliability. When there are out-of-compliance findings for any of these reviews or audits, Plans of Correction are required, and the State follows these plans with reviews to assure correction of system issues which contribute to out of compliance findings. Should corrections not be made, the option of suspension or revocation of a provider's privileges to bill is available.
- Investigations of incidents and complaints that are unresolved at the local level or that have the appearance of conflict of interest with the LME. If there are allegations of abuse, neglect or exploitation, a report will be made to the County Department of Social Services. Incidents and complaints regarding licensed facilities are investigated by or jointly with the Division of Facility Services.
- Track requests for reconsideration and resolutions of requests for reconsideration.
- Review Quarterly Reports of monitoring and incidents submitted by the LME.
- Track and investigate deaths of individuals. Deaths of individuals residing in licensed facilities are reported to the Division of Facility Services. Other deaths are reported to DMH/DD/SAS.

Quality Measures

The following table describes the Quality Framework domains that DMH/DD/SAS is currently using or will use to guide the measurement of system performance, both for CAP-MR/DD waiver and the MH/DD/SAS system.

Domain	Desired Outcome
Participant Access	Individuals have ready access to home and community-based services and supports in their communities.
Person Centered Planning and Service Delivery	Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.
Provider Capacity and Capabilities	There are sufficient providers and they possess and demonstrate the capability to effectively serve participants.
Participant Safeguards	Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.
Participant Rights and Responsibilities	Participants receive support to exercise their rights in accepting personal responsibilities.

Domain	Desired Outcome
Participant Outcomes	Participants achieve desired outcomes.
Participant Satisfaction (with system and processes)	Participants are satisfied with their services.
System Performance	The system supports participants efficiently and effectively and constantly strives to improve quality.

APPENDIX K.
FUNDING CHECKLIST FOR PLANS OF CARE

Individual: _____ Case Manager: _____ ___Initial ___Annual
__Cost Revision (____ Indicated on Plan)

	MR-2 (CAP-MR/DD Annual Plans only)		**Case Management/Signature Page (Annual and Initial Plans)**
__	POC submitted by AP/LME deadline.	__	Consumer and/or legally responsible person, if there is one, signs/dates in CAP section (if CAP funded) or in Plan Section (if not CAP funded).
__	MR-2 Enclosed with current psychological.		
__	Signed and dated by QP or physician or licensed psychologist.		
__	Signed by LME staff.	__	Case manager signs/dates .
__	Signature dated during birthday month or o earlier than one month prior to the birthday month and before responsible person signs POC		
__	ICF-MR Level of Care supported by MR-2.		
	MR-2 (CAP-MR/DD Initial Plans only)		**Attachments**
__	POC submitted within 60 days of MR-2 prior approval deadline and AP/LME deadline	__	NC-SNAP (for Revisions: only if changed)
__	MR-2 Enclosed and current psychological	__	Crisis plan
__	Signed/dated by physician and licensed psychologist before responsible person signs POC	__	Behavior plan as needed
	Signed by LME staff	__	Justification for equipment/supplies (CAP-MR/DD only)
__			
	POC (Initials and Annual Plans only)		**Cost Summary**
__	Residency indicated	__	Effective date is the latest of the following three dates: (1) prior approval; (2) Medicaid approval; (3) deinstitutionalization date (Initials only)
__	CAP-MR/DD Status indicated (CAP-MR/DD only)		
__	Legally Responsible Person indicated	__	Effective date is 1st day of the month following the birth month (Annual Plans only)
__	Diagnosis indicated		
__	Medication section completed	__	Frequency/How Many/How Often/# Months indicated
__	Medications match MR-2 (CAP-MR/DD only)	__	From/To dates indicated (MM/DD/YY)
__	Medications match diagnoses	__	Rates/Calculations are correct
		__	Total cost follows UR guidelines and processes
		__	Comments/calculations included for waiver supplies/equipment
	POC		
__	Strengths/Preferences indicated		
__	Issues/Needs indicated		
__	What we need to do to support this person related to health and safety issues is completed		
__	Process for back-up staff		
__	Outcomes based		
__	Strengths/Preferences/Issues/Needs		
__	What ___ How ___ Responsible Person ___ By When ___		
__	Service and Frequency		
__	Health and safety issues from assessments (i.e. MR-2 item 30-CAP-MR/DD) are addressed		
__	Outcomes for requested waiver equipment and supplies (CAP-MR/DD only)		
__	Justification for requested service or level of services		
__	Justification for services provided by family member/legal guardians		
__	Plan supports funding and is developed according to individual's assessed preferences and needs		
__	Other supports not identified in Cost Summary		

Check one: Approved _____ Denied _____
Reviewer:_____ Date:_____
Follow-up Issues:

APPENDIX L. PROVIDER QUALIFICATIONS LICENSURE AND CERTIFICATION CHART

The following chart indicates the requirements for the provision of each service under the waiver. Licensure, regulation, state administrative codes are referenced by citation. Standards not addressed under uniform state citation are attached.

Note: Wavier services cannot be provided to recipients by legally responsible relatives, i.e., spouse or parents/step-parents. These individuals cannot own or operate the provider agency providing services to their minor children/step-children or spouse. Services may be provided by relatives or friends (except for legally responsible relatives as noted above). Direct Care Staff must have expertise, as appropriate, in the field in which the service is being provided. Services provided by relatives and friends may be covered if relatives or friends meet the qualifications for providers of care. There are strict controls to assure that payment is made to the relative or friends in return for specific services rendered, and there is justification as to why the relative or friend is the provider of care, e.g., lack of other qualified provider in remote areas. Medicaid payment may be made to qualified parents of minor children or to spouses for extraordinary services requiring specialized skills (e.g., skilled nursing, physical therapy) which such people are not legally obligated to provide. Legal guardians of the person may provide waiver services to participants since they are not financially responsible for the participant.

Note: For the purposes of this waiver, a qualified professional refers to a qualified professional in the field of developmental disabilities.

NCAC= North Carolina Administrative Code, GS= General Statute, APSM= Administrative Procedures and Standards Manual

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Personal Care	Provider Agency/Organization		Providers Agencies/ Organizations are certified by the LME	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person-centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200.
	Local Management Entity (LME)		LMEs are approved by DHHS	Driving record must be checked if providing transportation.
	Home Care Agency	Licensed by the Division of Facility Services (DFS) as a Home Care Agency		**Staff providing enhanced personal care have additional training/instruction specific to the medical and/or behavioral needs of the consumer.**

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Respite	Provider Agency/Organization Local Management Entity (LME)	As applicable, licensed by DFS as a respite care facility in accordance with G.S. 122C	Providers Agencies/ Organizations are certified by LMEs LMEs are approved by DHHS	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person-centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation. **Staff providing enhanced respite care have additional training/instruction specific to the medical and/or behavioral needs of the consumer.**
Respite-Institutional	State regional MR facility		Certified by DFS as an ICF-MR in accordance with federal conditions of participation	State MRCs have deemed status for all training and documentation requirements. This type of respite must be provided in a Medicaid ICF-MR bed in a State regional mental retardation facility.
Respite Nursing	Provider Agency/ Organization Local Management Entity (LME)		Providers Agencies/ Organizations are certified by the LME LMEs are approved by DHHS	Worker Qualifications: RN or LPN Service providers must have a criminal record check and healthcare registry check. Driving record must by checked if providing transportation.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Home and Community Support (HCS)	Provider Agency/Organization Local Management Entity (LME)		Providers Agencies/ Organizations are certified by the LME LMEs are approved by DHHS	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person-centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.
Residential Supports	Provider Agency/Organization Local Management Entity (LME)		Providers Agencies/ Organizations are certified by LME/ Area Authorities/County Programs LMEs are approved by DHHS	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person-centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.
Day Supports	Provider Agency/Organization Local Management Entity (LME) Licensed Developmental Day Programs	10A NCAC 27G as applicable Licensed Developmental Day Programs-.2200-.2400	Providers Agencies/ Organizations are certified by the LME LMEs are approved by DHHS Licensed Developmental Day Programs- license approved by the Division of Child	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person-centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation. Licensed Developmental Day Programs- trained individual with at least a high school diploma or high school equivalency supervised by a Qualified Professional or

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
			and Maternal Health	Associate Professional
	Licensed Day Care Programs	Licensed Day Care Programs-GS 110 Article 7	Licensed Day Care Programs- Private Providers are certified by LME	Licensed Day Care Programs- general and license requirements only
	Adult Day Care Programs	Adult Day Care Programs	Adult Day Care and Adult Day Health Programs-Certified as Adult Day Care or Adult Day Health Facility by Division of Aging	Adult Day Health and Adult Day Care Programs- general and certification requirements only
	Before and After School Day Care Programs operated by NC Public School System		Before and After School Day Care Programs operated by NC Public School System and qualified by LMEs	Before and After School Day Care Programs operated by NC Public School System-qualified by the LME- general and license requirements only
Supported Employment	Provider Agency/ Organization		Providers Agencies/ Organizations are certified by LME/ Area/County Programs	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person-centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.
	Local Management Entity (LME)		LMEs are approved by DHHS	

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Home Modifications	Local Management Entity (LME)		LMEs are approved by DHHS	Must meet applicable state and local building codes. Purchasing follows LME business procedures.
Specialized Consultative Services	Provider Agency/Organization Local Management Entity (LME)		Providers Agencies/ Organizations are certified by LME LMEs are approved by DHHS	Worker Qualifications: Must hold appropriate NC license for PT, OT, ST, psychology, nutrition; or state certification for Recreation Therapy.
Transportation	Local Management Entity (LME)		LMEs are approved by DHHS	Insurance coverage as required by NC law, driving record check and criminal background checks.
Specialized Equipment and Supplies	Local Management Entity (LME)		LMEs are approved by DHHS	Purchasing follows LME business procedures.
Augmentative Communication	Local Management Entity (LME		LMEs are approved by DHHS	Purchasing follows LME business procedures. Augmentative Communication Devices must be recommended by speech/language pathologist licensed to practice in NC. Augmentative Communication Technology Professionals are individuals with hands on knowledge and expertise with augmentative communication devices.
Personal Emergency Response System	PERS Agency	Business license		Must be able to provide 24/hour service.

SERVICE	PROVIDER	LICENSE	CERTIFICATION	OTHER STANDARD
Individual/ Caregiver Training and Education	Provider Agency/Organization Local Management Entity (LME)		Providers Agencies/ Organizations are certified by LME LMEs are approved by DHHS	Worker Qualifications: Must have expertise as appropriate, in the field in which the training is being provided. Driving record must be checked if providing transportation.
Crisis Services	Provider Agency/Organization Local Management Entity (LME		Providers Agencies/ Organizations are certified by LME LMEs are approved by DHHS	Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0100-.0200. Client specific competencies to be met as identified by the individual's person-centered planning team and documented in the plan of care. Direct care staff must have a criminal record check. A healthcare registry check is required in accordance with 10A NCAC 27G.0200. Driving record must be checked if providing transportation.
Vehicle Adaptation	Local Management Entity (LME)			Must meet safety codes if applicable to the modification being provided.
Adult Day Health	Adult Day Health Care Facility		Certified by the NC Division of Aging	Adult Day Health and Adult Day Care Programs- general and certification requirements only

APPENDIX M. UTILIZATION REVIEW GUIDELINES

Utilization Review Guidelines for CAP-MR/DD Recipients Residing at Home

Home = own home or with natural family

Service	*LEVEL 1 SNAP Index 24-44*	*LEVEL 2 SNAP Index 45-78*	*LEVEL 3 SNAP Index 80-92*	*LEVEL 4 SNAP Index 95-230*
Respite	576 hours/year	576 hours/year	576 hours/year	576 hours/year
Personal Care	40 hours/month	80 hours/month	120 hours/month	180 hours/month
Residential Supports	N/A	N/A	N/A	N/A
Home and Community Supports, Day Supports, Supported Employment	120 hours/month for any combination of these services	120 hours/month for any combination of these services	120 hours/month for any combination of these services	120 hours/month for any combination of these services

- Individuals at level 3 or 4 are eligible for Enhanced Respite and Enhanced Personal Care Services
- Hours of Home and Community Supports, Day Supports and Supported Employment can be exchanged for additional Personal Care hours, if indicated on the person centered plan

Utilization Review Guidelines for CAP-MR/DD Recipients in Residential Placements

Residential = alternative family living or provider managed residences

Service	*LEVEL 1 SNAP Index 24-44*	*LEVEL 2 SNAP Index 45-78*	*LEVEL 3 SNAP Index 80-92*	*LEVEL 4 SNAP Index 95-230*
Respite	*576 hours/year	*576 hours/year	*576 hours/year	*576 hours/year
Personal Care	N/A	N/A	N/A	N/A
Residential Supports	Daily rate	Daily rate	Daily rate	Daily rate
Home and Community Supports, Day Supports, Supported Employment	120 hours/month for any combination of these services	120 hours/month for any combination of these services	120 hours/month for any combination of these services	120 hours/month for any combination of these services

- *Only available to individuals residing in alternative family living homes
- *Individuals at levels 3 and 4 are eligible for Enhanced Respite services
- Individuals in residential placements are only eligible to receive the community component of Home and Community Supports